



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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July 2, 2010

CERTIFIED MAIL #7003 0500 0003 1966 8718

Dallas Clinger, Administrator
Harms Memorial Hospital
P.O. Box 420
American Falls, ID 83211

RE: Harms Memorial Hospital, CCN# 131304

Dear Mr. Clinger:

Based on the revisit at Harms Memorial Hospital on June 18, 2010, by our staff, we have determined that Harms Memorial Hospital continues to be out of compliance with the Medicare Conditions of Participation on **C240 - 42 CFR §485.627 - Organizational Structure; C270 - 42 CFR §485.635 - Provision of Services; C330 - 42 CFR §485.641 - Periodic Evaluation & QA Review.**

The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Also enclosed is your copy of a Post-Certification Revisit Report (CMS-2567B), listing deficiencies that have been corrected. A similar form describing state licensing deficiencies is also enclosed.

In our letter to you dated May 21, 2010, we stated: "failure to correct the deficiencies and achieve compliance will result in our recommending that the Centers for Medicare and Medicaid Services (CMS) Region X Office, Seattle, Washington, terminate your approval to participate in the Medicare program."

Because of your failure to correct, we have made that recommendation. CMS will be in contact with you regarding the procedures, timelines, and appeal rights associated with this recommendation that must be followed.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mm
Enclosures

cc: Catherine Mitchell, CMS Region X Office
Debra Ransom, R.N., R.H.I.T., Bureau Chief
Steve Millward, Administrative Assistant to Randy May

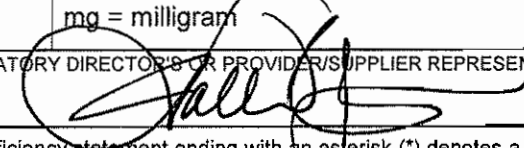
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/18/2010
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NAME OF PROVIDER OR SUPPLIER HARMS MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET AMERICAN FALLS, ID 83211
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{C 000}	<p>INITIAL COMMENTS</p> <p>The CMS Form 2567 (Statement of Deficiencies), dated 5/05/10, stated it was determined the hospital was not in compliance with 3 Conditions of Participation including 42 CFR Part 485.627 Organizational Structure, 42 CFR Part 485.635 Provision of services, and 42 CFR Part 485.641 Periodic Evaluation and Quality Assurance Review. During this follow up survey, it was determined the CAH was not in compliance with the same 3 Conditions of Participation. The following deficiencies were cited during the follow up survey. Surveyors conducting the re-visit were:</p> <p>Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS</p> <p>The following acronyms were used in the survey report:</p> <p>CAH = Critical Access Hospital CEO = Chief Executive Officer CFR = Code of Federal Regulations CMS = Centers for Medicare and Medicaid Services DON = Director of Nursing Duoneb = a combination of 2 medications used during an inhalation treatment to treat difficulty breathing ER = emergency room GI = gastrointestinal gm = gram HIM = Health Information Management IDAPA = Idaho Administrative Procedures Act IM = intramuscular IV = intravenous MAR = medication administration record mg = milligram</p>	{C 000}	<p>RECEIVED</p> <p>JUL 19 2010</p> <p>FACILITY STANDARDS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	CEO/ADMINISTRATOR	14 JULY 2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{C 000}	Continued From page 1 ml = milliliter MS = Morphine Sulfate NP = nurse practitioner OP = outpatient PO = orally PRN = as needed QI = quality improvement RN = registered nurse svn-tx = small volume nebulizer treatment TID = three times a day X = times	{C 000}			
{C 240}	485.627 ORGANIZATIONAL STRUCTURE Organizational Structure This CONDITION is not met as evidenced by: Based on staff interview and review of policies, patient records, meeting minutes, credentials files, and state hospital licensure rules, it was determined the CAH failed to ensure an organizational structure was in place sufficient to 1) provide safe and effective care to patients and 2) ensure all Conditions of Participation were met. This resulted in the inability of the CAH to develop systematic approaches to patient care and to respond to identified problems. The findings include: 1. Refer to C241 as it relates to the failure of the Governing Body to assume full responsibility for determining, implementing, and monitoring policies governing the CAH's operation. 2. Refer to C-270, Condition of Participation: Provision of Services and related standard level deficiencies as they relate to the failure of the Governing Body to ensure patients received appropriate care and services.	{C 240}	C 240 485.627 ORGANIZATIONAL STRUCTURE 1. Refer to C-241 as it relates to the failure of the Governing Body to assume full responsibility for determining, implementing, and monitoring policies governing the CAH's operation. 2. Refer to C-270 Condition of Participation: Provision of Services and related standard level deficiencies as they relate to the failure of the Governing Body to ensure patients received appropriate care and services. 3. Refer to C-330 Condition of Participation: Periodic Evaluation and Quality	23 JULY 10	

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{C 240}	Continued From page 2 3. Refer to C-330, Condition of Participation: Periodic Evaluation and Quality Assurance Review and related standard level deficiencies as they relate to failure of the Governing Body to ensure a data driven QA program was developed and implemented. The cumulative effect of these negative systemic practices limited the capacity of the CAH to furnish services of an adequate level or quality.	{C 240}	Assurance Review and related standard level deficiencies as they relate to failure of the Governing Body to ensure a data driven QA program was developed and implemented.		
{C 241}	485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment. This STANDARD is not met as evidenced by: Based on staff interview and review of policies, patient records, meeting minutes, credentials files, and state hospital licensure rules, it was determined the Governing Body failed to assume full responsibility for determining, implementing, and monitoring policies governing the CAH's operation. This lack of oversight directly impacted the care of 1 of 1 patient (#9) reviewed who was treated by a provider operating under a restricted license and had the potential to impact all patients seeking medical services at the CAH. The failure of the Governing Body to ensure policies were developed and to monitor care in relation to those policies resulted in a lack of direction to staff. The findings include:	{C 241}	C 241 485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL At the Board of Trustees Meeting held on June 21, 2010, Dallas Clinger, CEO/Administrator, read through each of the citations that were received on the initial survey completed May 5, 2010. He also requested that an Operations Committee of the Board of Trustees be appointed to meet to be informed of the progress of the survey citations and the plan of correction. After the initial meetings for the survey, the committee will then meet on a regular basis to be informed of the operations of the facility. The Operations Committee (consisting of Dallas Clinger - CEO/Administrator, Richard Wallace - Board Member, Lisa Qualls - Board Member, James		23 JUL 10

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{C 241}	<p>Continued From page 3</p> <p>1. The CEO was interviewed on 6/16/10 at 8:55 AM. He stated the hospital's Board of Trustees met on 5/17/10 following the 5/05/10 survey. He stated the hospital did not have the recertification survey report at the time of the meeting (CMS Form 2567). Draft minutes of the 5/17/10 board meeting stated the recertification survey had taken place. The minutes stated the hospital had received one serious citation related to "the condition of participation on sterilization of scopes." The minutes did not mention the deficiencies related to Organizational Structure or Quality Assurance. The CEO stated the board had not met since receiving the survey report.</p> <p>In the same interview, the CEO stated the QI Coordinator had met with members of the QI Committee individually but he said the Committee as a whole had not met since the survey. The CEO stated the medical staff met shortly after the survey and before the hospital had received the survey report. The CEO stated none of the above entities had met following the receipt of the survey report to discuss the findings of the report, to review hospital systems, and to develop a plan of correction.</p> <p>The Governing Body failed to ensure persons responsible for the operation of the hospital had met and reviewed operations in order to correct identified deficiencies.</p> <p>2. Idaho state licensure requirements at IDAPA 16.03.14.350.03 require the hospital to form a Pharmacy and Therapeutics Committee composed of members of the medical staff, the Director of Pharmaceutical Services, the DON, hospital administration and other health</p>	{C 241}	<p>Chapman, Jr. - Board Member) met on July 2, 2010. At this initial meeting of the Operations Committee, the survey report and the plan of correction for the survey completed May 5, 2010, was delivered to each of the members of the Operations. Since this meeting was held at 7:00 a.m. the official citations for the resurvey had not been received (an emailed copy was received by the CEO at 4:52 p.m. on Friday, July 2) therefore, the CEO reviewed with the Operations Committee his notes from the exit interview. The Operations Committee also met again on July 13, 2010 at which time copies of the resurvey citations were given to each member of the committee along with copies of the letter from CMS dated July 9, 2010, Notice of intent to terminate effective 08/03/2010. Nanette Hiller, consultant with the Idaho Hospital Association, was invited to attend this meeting of the Operations Committee. The Committee discussed the survey and the process of the termination with Ms. Hiller. The Operations Committee determined that a meeting of the full Board of Trustees should be held to inform all members of the board of the resurvey citations and the intent to terminate. A meeting of the full Board of Trustees was held at 5:00 pm on Thursday, July 15, 2010. The</p>		

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{C 241}	<p>Continued From page 4</p> <p>disciplines as necessary to develop written policies and procedures for medication use. While the hospital had a Pharmacy and Therapeutics Committee which met monthly in conjunction with the Medical Staff meetings, the Governing Body of the hospital did not ensure a pharmacist was included on the committee.</p> <p>Five monthly Medical Staff meeting minutes between 1/13/10 and 5/12/10 were reviewed. None of these minutes listed the pharmacist was in attendance. The pharmacist was interviewed on 6/16/10 at 10:20 AM. He stated he was not a part of the Pharmacy and Therapeutics Committee and did not attend the meetings. He further stated he did not review medication errors that occurred at the hospital. He said he did not oversee the use of IV medications and solutions at the hospital. He stated he did not review areas of the hospital where medications were stored, except for the pharmacy.</p> <p>The Governing Body failed to ensure the pharmacist participated as a member of the Pharmacy and Therapeutics Committee. The Governing Body failed to ensure the pharmacist had oversight of medications and IV solutions at the hospital.</p> <p>3. The Governing Body failed to ensure an effective system to identify and prevent medication/prescription errors had been developed and implemented.</p> <p>The hospital had identified only 2 medication/prescription errors between 10/20/09 and 6/14/10, the start of the follow-up survey. Surveyors identified 10 medication/prescription errors between 6/11/10 and 6/17/10.</p>	{C 241}	<p>board received a full and complete copy of the resurvey citations and the plan of correction including all new policies and Medical Staff bylaw changes. The Board of Trustees will act to accept these new policies and Medical Staff bylaw changes on their monthly meeting scheduled for July 26, 2010 at 7:00 pm.</p> <p>Nanette Hiller from the Idaho Hospital Association attended the Quality Improvement Committee meeting which was held on July 13, 2010. She reviewed with us some of the Quality Improvement goals and how we could make our Committee more effective with meaningful, measurable and attainable goals and how to make it a data driven committee. She also reviewed the survey results and the plan of correction and new policies that were written to correct deficiencies.</p> <p>A new policy was written to require the Pharmacist to attend at least quarterly, the Pharmacy and Therapeutics Committee that is held in conjunction with the Medical Staff meetings. Please see attached Policy. Additionally, policies were written to assure security and control of distribution of pharmaceuticals, access to the pharmacy, discontinued/outdated drugs, IV</p>		

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{C 241}	<p>Continued From page 5</p> <p>The QI Coordinator was interviewed on 6/16/10 at 9:45 AM. She stated a system to actively search for medication errors had not been developed. She stated the Pharmacy Technician conducted some medical record reviews. She acknowledged the Pharmacy Technician did not have a medical background and had not been trained to identify medication errors.</p> <p>The Governing Body failed to develop a system to prevent medication errors.</p> <p>4. The Governing Body failed to restrict the practice of 1 of 1 Allied Medical Staff member (Staff I) with a restricted license.</p> <p>Staff I was a NP. Her credentials file contained a letter from the Board of Nursing, dated 11/06/07, which stated she was not allowed access to prescribe or dispense controlled substances and/or scheduled drugs. Her privileges had not been modified. The privilege list did not state how scheduled medications would be ordered if needed.</p> <p>The inability to order scheduled medication led to confusion. Patient #9's medical record documented a 58 year-old female who was brought to the ER on 6/11/10 after a fall from a horse. She complained of severe pain in her right upper leg. She was examined by Staff I. An order by Staff I on the "ER PROVIDER ORDER AND DOCUMENTATION RECORD", that was undated and untimed, stated "MS [morphine sulfate] 4 mg X 2." The order stated Staff J, another NP, had approved the order. Staff J had not signed the order. The medical record stated</p>	{C 241}	<p>competence and personnel monitoring, IV preparations and administrations, defining and identifying medication errors and others to improve the oversight of the pharmacist over the pharmacy in our facility. Additionally, our hospital has a consulting contract with Portneuf Medical Center to help with questions or issues that we may be facing.</p> <p>The pharmacist for our facility was integral in the writing and development of these policies. Meetings with the DON, the administrator, the Pharmacist, the Pharmacy tech and the Director of Professional Services were held on July 1, 2010 and on July 8, 2010 to discuss the survey, the plan of correction, the new policies needed and the implementation of the changes to come into compliance.</p> <p>On July 2, 2010 the CEO/Administrator met with the Allied Medical Staff Member to review the procedures that had been in place since August 2007 regarding her limited license to prescribe medications. In August 2007 a letter was written and sent by certified mail to this Allied Medical Staff Member explaining the procedures for her to prescribe scheduled medications. This letter was</p>	

approved by the Medical Staff and the Board of Trustees in 2007 and was signed by the Chief of Staff and the Administrator. Therefore, a formal written protocol was in place at the time of the survey. This letter was again reviewed with her. Since the letter is a part of her personnel record it is not attached, but a photocopy of the certified mailing is attached. The letter states in part "We will need to inform the hospital's acute Director of Nursing so that she can inform her staff of this new procedure. We anticipate the notification to read as follows: (Staff I) has not renewed her certificate to prescribe scheduled medications, therefore, when she is covering the emergency department and has a patient that requires a prescription for a scheduled drug, (Staff I) will call the backup doctor and inform him of the recommendation and then she will hand the telephone to the RN on duty for the backup doctor to make a telephone order. This procedure will take effect immediately and continue until her certificate has been renewed." On July 7, 2010 this notification was again placed in the nurse's communications notebook with a notice of "Do not remove". It was also placed on the bulletin board at the nurse's station. A copy of this

notification is attached. The DON included this reminder of current procedures in her in-service that she conducted on Thursday, July 15, 2010 with the acute nursing staff. A policy was written by Human Resources to address the issue of providers with restricted licenses. A copy of this policy is attached.

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{C 241}	Continued From page 6 morphine was administered to Patient #9 at 8:02 PM and at 8:40 PM on 6/11/10. During an interview with the DON on 6/17/10 at 11:15 AM, she verified the record of Patient #9 and the morphine order. She stated Staff I had a restricted license and was unable to prescribe narcotics. The DON stated there was an unwritten arrangement with the medical and nursing staff in which staff were instructed to call the back up physician or other nurse practitioner for narcotics orders. The DON stated, in the case of Patient #9, it was not documented that communication with another provider was made. The Chief of the Medical Staff was interviewed on 6/22/10 at 10:20 AM. He stated he thought Staff I was not allowed to write orders for scheduled medications. He stated nurses would have to obtain an order from another provider. He said he did not know if a specific procedure to do this had been developed.	{C 241}			
{C 270}	The Governing Body failed to define Staff I's practice and identify how nursing staff could obtain valid orders for scheduled medications. 485.635 PROVISION OF SERVICES Provision of Services This CONDITION is not met as evidenced by: Based on review of policies, staff interview, and review of medical records, it was determined the CAH failed to ensure services were provided in accordance with written policies and procedures. This resulted in the inability of the CAH to provide consistent services based on sound practices. The findings include:	{C 270}	C 270 485.635 PROVISION OF SERVICES Refer to C-271 as it relates to the failure of the CAH to ensure services were provided in accordance with written policies. Refer to C-276 as it relates to the failure of the CAH to follow established standards of practice in the management of medications.	23 JULY 10	

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{C 270}	Continued From page 7	{C 270}			
{C 271}	<p>1. Refer to C271 as it relates to the failure of the CAH to ensure services were provided in accordance with written policies.</p> <p>2. Refer to C276 as it relates to the failure of the CAH to follow established standards of practice in the management of medications.</p> <p>The cumulative effect of these negative systemic practices limited the capacity of the CAH to furnish services of an adequate level or quality.</p> <p>485.635(a)(1) PATIENT CARE POLICIES</p> <p>The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, review of medical records and hospital policies, it was determined the CAH failed to ensure services were furnished in accordance with appropriate written policies. Staff failed to follow written policies related to the writing complete medication orders, documenting services provided to patients, the provision of IV therapy, and ensuring orders were accurately written. This directly impacted 10 of 15 ER and OP department patients (#1, #2, #4, #5, #6, #7, #9, #12, #14, and #15), whose records were reviewed. This resulted in the inability of the hospital to ensure effective care was provided in accordance with appropriate orders from practitioners. The findings include:</p> <p>1. Staff failed to write complete orders in accordance with written policy.</p>	{C 271}	<p>C 271 485.635(a)1 PATIENT CARE POLICIES</p> <p>1. All nursing staff was in-serviced about the policy related to the proper documenting of telephone, written and verbal orders on 07/15/2010 by the Director of Nursing. All charts are audited by the end of the RN's shift for completeness of medication orders to include the date, time, name of drug, dosage, quantity and/or duration, route, frequency, name of individual prescribing the medication and his/her licensure, and name and level of licensure of the individual receiving and documenting the order. In addition all charts are audited a second time by the Director of Nursing to ensure the correct</p>	23 July 10	

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{C 271}	<p>Continued From page 8</p> <p>A policy titled "Telephone, Verbal, and Written orders for Medication," dated 5/15/10, stated orders "would include the following criteria:</p> <ul style="list-style-type: none"> -Date and time the order is prescribed -The name of the individual prescribing the drug and his/her licensure -The generic and brand name of the drug -Drug dosage -Quantity and/or duration -Route drug is to be administered -Frequency of administration -Age and weight of the patient when appropriate. -The reason the drug was ordered for the patient -Specific indications for use, as indicated -Name and level of licensure of the individual receiving and documenting the order." <p>Staff failed to follow this policy and wrote incomplete orders including:</p> <p>a. Patient #6's medical record documented a 92 year-old female who presented to the ER on 6/14/10 at 3:10 PM. She complained of chest and back pain. The "EMERGENCY ROOM RECORD" dated 6/14/10 and generated at the time of the visit, stated "Toradol 30 mg IM, Phenergan 50 mg IM, GI Cocktail po." (A GI cocktail is a mixture of ingredients to calm an upset stomach. Usually the major ingredient is a Maalox-type antacid.) This appeared to be written by Staff H, a RN. It was not clear that this was an order. The medications were simply listed on the form with no date or time or signature. It did not state when the medications were to be given. The Toradol and Promethazine were documented as given at 3:15 PM. The GI Cocktail was documented at 3:30 PM</p>	{C 271}	<p>documentation of telephone, written and verbal orders. A medication error Quality Management Memo (QMM) incident report will be initiated in the event telephone, written and verbal orders are not documented correctly and the nurse who made the error will receive further education and counseling from the Director of Nursing. Repeated failure on the part of nursing staff to correctly document telephone, written and verbal orders will result in disciplinary action. The Medical Records director will be responsible to ensure that all telephone or verbal orders are signed by the provider who ordered them within 48 hours. The Medical Records director will generate a QMM incident report for providers who fail to sign verbal or telephone orders within 48 hours and will submit the QMM to the CEO for follow up. This corrective measure will be instituted by 07/23/2010 and will be monitored by the Director of Nursing, who will ensure that chart audits are done, and the Director of Medical records, who</p>		

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{C 271}	<p>Continued From page 9</p> <p>Staff H, the RN who cared for Patient #6, was interviewed on 6/17/10 at 10:10 AM. She stated she gave the medications to Patient #6. She confirmed a complete order for the medications was not present in the medical record. She stated the NP rushed up from the clinic, saw Patient #6, and rushed back to the clinic. Staff H stated she did not know what the hospital's policy was regarding complete medical orders.</p> <p>b. Patient #7's medical record documented a 62 year-old female who presented to the ER on 6/12/10 at 5:17 PM. She complained of difficulty breathing. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD", written by Staff J, a NP, and dated 6/12/10, stated Patient #7 had "bad" upper respiratory symptoms for 4 days. The form stated Patient #7 had a history of chronic obstructive pulmonary disease and said she "can't talk for periods because can't catch breath." The form stated "Duoneb svn-tx." This was not noted as an order by Nurse K, the RN who examined Patient #7. The time it was written was not noted. The number of ampules to be given was not documented. The form did not state if the drug should be administered immediately or if it could be postponed. The Duoneb was documented as administered at 7:40 PM, 2 hours and 23 minutes after Patient #7 arrived at the ER.</p> <p>The pharmacist was interviewed on 6/16/10 at 10:20 AM. He reviewed Patient #7's medical record and stated the failure to write a complete order and administer Duoneb in a timely manner constituted a medication error.</p> <p>c. Patient #7 returned to the ER on 6/14/10 at 2:47 PM, complaining of shortness of breath and</p>	{C 271}	<p>will ensure that verbal orders are signed, for compliance.</p> <p>2. All providers for HMHD were educated regarding the need to document and/or dictate examinations of patients at the time of service by the CEO at the Medical Staff meeting held 07/14/2010. Charts will be audited by the Medical records director for compliance of the providers documenting the results of their examination at the time of service. In the event the examination is not documented a QMM will be generated which will go to the Chief Executive Officer (CEO) for review. The CEO will provide further education and counseling to medical staff regarding the necessity of documenting/dictating the examination at the time of service. Repeated failure to comply with this corrective measure will result in disciplinary action. This corrective action will be completed by 07/23/2010. The CEO will be responsible to ensure compliance with this corrective measure by reviewing QMM's</p>	

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{C 271}	<p>Continued From page 10</p> <p>cough. The "EMERGENCY ROOM RECORD" stated Patient #7 received "Prednisone 40 mg 2 pills" at 3:15 PM. An order for the Prednisone was not documented in the medical record.</p> <p>The pharmacist was interviewed on 6/16/10 at 10:20 AM. He reviewed Patient #7's medical record and confirmed the lack of a medication order.</p> <p>d. Patient #5, an 88 year-old female was seen as an OP on 6/14/10 at 11:53 AM, for left leg and hip pain. A verbal order was given to Staff H, a RN, by Patient #5's physician for Decadron (a steroid), and Toradol (an anti-inflammatory). The verbal order was untimed, and was not signed by the physician.</p> <p>In an interview with Staff H, the RN, on 6/17/10 at 10:10 AM, she confirmed Patient #5's orders were incomplete.</p> <p>e. Patient #9, a 58 year-old female was brought to the ER on 6/11/10 after a fall from a horse. She reported she had severe pain in her right upper leg. An entry by Staff I, a NP, on the "ER PROVIDER ORDER AND DOCUMENTATION RECORD" was undated and untimed. It read "MS 4 mg X 2, [Staff J, another NP] approved." There was no signature by Staff J. Patient #9's record also documented IV fluids had been administered, although there was no order for the IV fluids.</p> <p>An interview with the CAH's pharmacist was completed on 6/16/10 at 10:30 AM. He reviewed Patient #9's medication order. He indicated since the order was not complete it would be considered a medication error.</p>	{C 271}	<p>and following up on them as appropriate.</p> <p>3. All nursing staff was in-serviced about the need to monitor all patients who receive medication in the Emergency or Outpatient Departments for 15 minutes, and the requirement to obtain repeat vital signs following the administration of the medication to monitor for possible side effects of the medication. All Emergency/Outpatient charts will be audited during the nurse's shift to ensure compliance with monitoring the patient for a minimum of 15 minutes, and obtaining repeat vital signs, following the administration of medication. In addition, all charts will be audited by the Director of Nursing to ensure that all patients who receive medication in the Emergency/Outpatient Departments will be monitored for 15 minutes following the administration of the medication, and that repeat vital signs are done. A QMM incident report will be generated for all instances where it is determined that patients receiving medication in</p>		

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{C 271}	<p>Continued From page 11</p> <p>f. Patient #12, a 16 year-old male came to the ER on 6/13/10 at 7:50 PM with severe sore throat pain. The record stated he was evaluated by Staff I, a NP. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD" stated "Amoxicillin 1 gm PO now." The order was not dated, timed, or signed. It was not clear whether the nurse or the practitioner had written the order. The order was not noted by a nurse, although the medication was documented as given at 8:05 PM.</p> <p>In an interview on 6/17/10 at 11:15 AM, the DON reviewed the record of Patient #12 and confirmed the documentation.</p> <p>In an interview on 6/16/10 at 10:30 AM, the CAH's pharmacist reviewed Patient #12's medication order. He stated since the order was not dated, signed or timed, it would be considered a medication error.</p> <p>g. Patient #15, a 12 year-old male came to the ER on 6/16/10 with complaints of a sore throat. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD" had a verbal order from Staff I, a NP, that was undated and untimed, for "Azithromycin 200/5 ml-PO Now, give 5 ml, then dispense remainder of bottle with instructions to take 2.5 ml every day X 4 days."</p> <p>In an interview on 6/17/10 at 11:15 AM, the DON reviewed the record of Patient #15 and stated the nurse was responsible for ensuring the record was complete, which would include the time and date on the orders. The DON stated the record for Patient #15 documented the NP had seen the patient. She stated the CAH had a difficult time with the providers writing their own orders.</p>	{C 271}	<p>the Emergency/Outpatient Departments were not monitored for a minimum of 15 minutes and/or repeat vital signs were not done. The Director of Nursing will provide further education and counseling to staff who fail to do the monitoring of patients for 15 minutes. Repeated failure on the part of the nursing staff to correctly monitor patients will result in disciplinary action. This corrective measure will be instituted on 07/23/2010 and will be monitored by the Director of Nursing for compliance by the auditing of 100% of charts.</p> <p>4. All nursing staff was in-serviced regarding the need to utilize the read back process to prevent miscommunication on 07/15/2010 by the Director of Nursing. The policy "Verbal and Written Orders, General" has been updated to include how the nursing staff will document the read back process. All Emergency/Outpatient charts will be audited during the nurse's shift to ensure compliance of staff with following the policy to read back telephone or verbal orders to</p>		

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{C 271}	<p>Continued From page 12</p> <p>h. Patient #14, a 42 year-old female, came to the ER on 6/15/10, with a complaint of right sided headache for 2 hours. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD" had an order from Staff I, a NP, that was undated and untimed, for "Flexeril 10 mg PO Now," and "dispense Flexeril 10 mg X 2 tabs to take home."</p> <p>In an interview on 6/16/10 at 10:30 AM, the pharmacist reviewed Patient #14's medication order. He stated the since the order was not dated or timed, it would be considered a medication error.</p> <p>In an interview on 6/17/10 at 11:15 AM, the DON reviewed the record and confirmed the medication order entry for Patient #14. The DON stated the nurse was responsible for ensuring the record was complete, which would include the time and date on the orders. The DON stated the problem of complete documentation has been an ongoing problem with both the providers and nursing staff. The DON said the policy of the CAH was to minimize verbal orders when the provider was available and present.</p> <p>The hospital failed to ensure complete orders were written and signed.</p> <p>2. Practitioners failed to document examinations of patients in accordance with written policy. Examples include:</p> <p>a. Patient #6's medical record documented a 92 year-old female who presented to the ER on 6/14/10 at 3:10 PM. She complained of chest and back pain. The "EMERGENCY ROOM RECORD," stated Patient #6 received Toradol 30</p>	{C 271}	<p>prevent miscommunication. In addition all charts will be audited by the Director of Nursing to ensure staff members are complying with the policy to read back telephone or verbal orders to prevent miscommunication. In the event the read back process is not documented, a QMM incident report will be generated and the Director of Nursing will provide further education and counseling to the nurse who failed to follow the procedure. Repeated failure to follow the procedure will result in disciplinary action. This corrective measure will be instituted on 07/23/2010 and will be monitored by the Director of Nursing for compliance by auditing 100% of charts.</p>	

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{C 271}	<p>Continued From page 13</p> <p>mg and Promethazine 50 mg by injection at 3:15 PM. The record stated she received a "GI Cocktail" at 3:30 PM. The "EMERGENCY ROOM RECORD" stated Patient #6 was discharged at 4:30 PM. The "EMERGENCY ROOM RECORD" stated Patient #6 was examined by Staff J, a NP, but did not state a time. Documentation of the examination by the NP was not present in the medical record as of 6/17/10.</p> <p>The HIM Director was interviewed on 6/17/10 at 11:00 AM. She reviewed Patient #6's medical record. She stated the NP who examined Patient #6 had not dictated an examination note.</p> <p>b. Patient #7's medical record documented a 62 year-old female who presented to the ER on 6/14/10 at 2:47 PM complaining of shortness of breath and cough. The "EMERGENCY ROOM RECORD" stated Patient #7 received "Prednisone 40 mg 2 pills" at 3:15 PM. The "EMERGENCY ROOM RECORD" stated a "provider" examined Patient #7 at 3:05 PM. Documentation of the examination by the provider was not present in the medical record as of 6/17/10.</p> <p>The HIM Director was interviewed on 6/17/10 at 11:00 AM. She reviewed Patient #7's medical record. She stated Staff J, the NP who examined Patient #7, had not dictated an examination note.</p> <p>c. Patient #12 was a 16 year-old male who came to the ER on 6/13/10 at 7:50 PM, with severe sore throat pain. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD" did not contain notes or a provider signature, although the "EMERGENCY ROOM RECORD" dated 6/13/10, indicated the provider (Staff I, a NP) had arrived</p>	{C 271}			

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{C 271}	<p>Continued From page 14 at 7:56 PM to assess Patient #12.</p> <p>In an interview on 6/17/10 at 11:15 AM, the DON reviewed the record and confirmed Patient #12 had no evidence of dictation or written notes by Staff I.</p> <p>d. Patient #14 was a 42 year-old female who came to the ER on 6/15/10 with a complaint of right sided headache for 2 hours. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD," undated and untimed, had a note entry of assessment by Staff I, a NP. It stated "Muscle tension headache, plan: Flexeril 10 one, TID PRN." Documentation was not present that the NP had examined Patient #14 or that she had dictated a note of her examination.</p> <p>In an interview on 6/17/10 at 11:15 AM, the DON reviewed the record. She confirmed an appropriate note of the NP's findings was not documented. The DON stated Staff I often dictated notes for ER visits, but said there was no evidence a note had been dictated.</p> <p>Practitioners did not document assessments of patients.</p> <p>3. The CAH failed to follow written policies related to monitoring and assessment of outpatients.</p> <p>The policy "Medication Administration," dated 5/15/10, stated all patients receiving a medication in the outpatient department will be monitored for 15 minutes following the administration of the medication to check for adverse reactions. The policy did not reference any exceptions to the 15 minute rule. Patients were not monitored for the required time frames. Examples include:</p>	{C 271}			

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{C 271}	<p>Continued From page 15</p> <p>a. Patient #1 was a 66 year-old male, who received daily antibiotic therapy for osteomyelitis (an infection involving the bone) in his heel. On 6/13/10 Patient #1's infusion of Cubicin and Invanz (both antibiotics) was started at 8:10 AM. The record indicated the infusion was completed at 8:40 AM, and Patient #1 was discharged at 8:50 AM, which was 10 minutes after the infusion was completed.</p> <p>In an interview on 6/16/10 at 11:00 AM with Staff B, a RN, she confirmed Patient #1 was discharged 10 minutes after the antibiotic was completed. She stated the infusion for Patient #1 infused over 30 minutes, and as he had been receiving the medication on a daily basis, she felt he no longer required the 15 minute evaluation.</p> <p>b. Patient #2, a 28 year-old male received daily antibiotic therapy for a salivary gland infection. On 6/11/10, Patient #2's infusion of Invanz was started at 5:15 PM. There was no documentation of the time the infusion was completed. The record stated Patient #2 was discharged at 5:45 PM.</p> <p>In an interview on 6/16/10 at 11:00 AM with Staff B, a RN, she confirmed she did not document when the antibiotic was completed. She stated the medication for Patient #2 infused over 30 minutes, and as he had been receiving the medication on a daily basis, she felt he no longer required the 15 minute evaluation.</p> <p>On 6/13/10 Patient #2's medical record stated the infusion of Invanz was completed at 5:30 PM, and he was discharged at 5:35 PM, 5 minutes after the infusion was completed.</p>	{C 271}		

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{C 271}	<p>Continued From page 16</p> <p>In an interview on 6/16/10 at 11:00 AM with Staff B, the RN, she stated Patient #2 had been receiving the medication on a daily basis, and she felt he no longer required the 15 minute evaluation.</p> <p>The CAH staff failed to monitor patients that had received medications, for 15 minutes as required in the medication administration policy.</p> <p>4. The policy "Verbal and Written Orders, General," not dated, and the policy "Telephone, Verbal and Written Orders for Medication," not dated, stated nursing staff would utilize the read back process and repeat the orders in their entirety to the prescribing practitioners to prevent miscommunication. The policies did not specify how nursing staff were to document this read back process.</p> <p>Nursing staff did not document a read back process for verbal and orders, resulting in medication orders which were not accurately written. Examples include:</p> <p>a. Patient #6's medical record documented a 92 year-old female who presented to the ER on 6/14/10 at 3:10 PM. She complained of chest and back pain. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD," dated 6/14/10, not timed or dated, stated "Toradol 30 mg IM, Phenergan 50 mg IM, GI Cocktail po." (A GI cocktail is a mixture of ingredients to calm an upset stomach. Usually the major ingredient is a Maalox-type antacid.) This was written by the nurse. The documentation did not state the orders had been read back to the prescribing practitioner.</p>	{C 271}			

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{C 271}	<p>Continued From page 17</p> <p>b. Patient #4's medical record documented a 56 year-old female who was seen on 6/14/10 as an outpatient. There was a telephone order written on a Harms Memorial Hospital prescription pad for "Valium, 7 mg, IM". The telephone order did not indicate it was read back to the prescribing physician.</p> <p>c. Patient #5's medical record documented an 88 year-old female that was seen as an outpatient on 6/14/10 at 11:53 AM for left leg and hip pain. A verbal order was written by Staff H, a RN, for Decadron (a steroid), and Toradol (an anti-inflammatory). The verbal order did not indicate it was read back to the prescribing physician.</p> <p>d. Patient #15's medical record documented a 12 year-old male that came to the ER on 6/16/10 with complaints of a sore throat. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD," had a verbal order entry from Staff I, a NP, that was undated and untimed, for "Azithromycin 200/5 ml-PO Now, give 5 ml, then dispense remainder of bottle with instructions to take 2.5 ml every day X 4 days." The verbal order did not indicate it was read back to the prescribing physician.</p> <p>Staff B, the Charge Nurse on duty, was interviewed on 6/24/10 at 8:30 AM. She stated the hospital had not developed a procedure defining how nurses would document the read back process for verbal and telephone orders. She said there was no way to tell if orders had been read back to the prescribing practitioner. She also stated nurses had the capability to record telephone orders from certain telephones.</p>	{C 271}			

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{C 271}	Continued From page 18 She stated there was no policy directing staff when or how to use this system.	{C 271}			
{C 276}	<p>A system had not been developed to document a read back process for verbal and telephone orders.</p> <p>485.635(a)(3)(iv) PATIENT CARE POLICIES</p> <p>[The policies include the following:]</p> <p>rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the CAH failed to ensure rules for the storage, handling, and administration of drugs were developed and implemented. The CAH also failed to ensure the pharmacist maintained oversight of medication policies and drug storage areas. This affected the care of 8 of 15 patients (#4, #5, #6, #7, #9, #12, #14, and #15) whose medical records were reviewed and had the potential to affect all patients at the CAH who received medications. This resulted in the inability of the CAH to accurately provide medications to patients. The findings include:</p> <p>1. The CAH's policies were insufficient to prevent</p>	{C 276}	<p>C 276 485.635(a)(3)(iv) PATIENT CARE POLICIES</p> <p>1. The policy and procedure for Medication errors has been updated jointly by pharmacy and nursing to include a definition of what constitutes a medication error. The policy also contains the means that the facility will employ to monitor for medication errors, (please refer to policy "Medication Errors", attached). By following the policy the facility will be able to find medication errors and provide education and counseling for staff committing errors, to better prevent them in the future. All nursing and pharmacy staff was in-serviced regarding the policy, and the need to generate a QMM incident report when discovering a medication error, on 07/15/2010 by the Director of Nursing. This corrective action will be completed by 07/19/2010</p>	23JULY10	

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{C 276}	<p>Continued From page 19</p> <p>medication errors. Nine medication/prescription errors were identified by surveyors that occurred between 6/11/10 and 6/17/10. These errors had not identified by CAH staff. The errors included:</p> <p>a. Patient #6's medical record documented a 92 year old female who presented to the ER on 6/14/10 at 3:10 PM. She complained of chest and back pain. The "EMERGENCY ROOM RECORD" stated Patient #6 received Toradol 30 mg and Promethazine 50 mg by injection at 3:15 PM. The record stated she received a "GI Cocktail" at 3:30 PM. These 3 medications were written by the nurse on an "ER PROVIDER ORDER AND DOCUMENTATION RECORD," dated 6/14/10. The medications were simply listed on the form. The name/signature of the individual who wrote order was missing, as was the date and time it was written. The document did not contain information related to when these medications were to be given or if they could be repeated.</p> <p>Staff H, the RN who cared for Patient #6, was interviewed on 6/17/10 at 10:10 AM. She stated she gave the medications to Patient #6. She confirmed an order for the medications was not present in the medical record. She stated Staff J, the NP who examined the patient, rushed up from the clinic, saw Patient #6, and rushed back to the clinic. Staff H stated she did not know what the hospital's policy stated regarding complete medical orders.</p> <p>The pharmacist was interviewed on 6/16/10 at 10:20 AM. He reviewed Patient #6's medical record and stated the administration of Toradol, Promethazine and the "GI Cocktail" constituted medication errors.</p>	{C 276}	<p>and the Director of Nursing will be responsible to ensure continued compliance, by ensuring that chart audits, 24 hour chart checks and pharmacy and nursing MAR reconciliation continues as per the policy.</p> <p>2. A Pharmacy Review committee meeting will be held monthly with the Director of Nursing, Pharmacist, Pharmacy Technician and compliance officer in attendance. All medication errors will be reviewed by the pharmacist. A log of medication errors will be maintained, with identifying information so that the type of medication error and the person committing the error can be identified. Using the log of medication errors, the pharmacy review committee can identify education that may need to be done with staff or individual staff members related to medication administration to prevent future medication errors. The Pharmacist will attend medical staff meetings at least quarterly as part of the pharmacy and therapeutics committee to report</p>	

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{C 276}	<p>Continued From page 20</p> <p>Nursing staff administered medications to Patient #6 without orders.</p> <p>b. Patient #7's medical record documented a 62 year old female who presented to the ER on 6/12/10 at 5:17 PM. She complained of difficulty breathing. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD," written by the NP and dated 6/12/10, stated Patient #7 had "bad" upper respiratory symptoms for 4 days. The form stated Patient #7 had a history of chronic obstructive pulmonary disease and said she "can't talk for periods because can't catch breath." The form stated "Duoneb svn-tx." What this meant was not clear. This was not noted as an order by the nurse. The time it was written was not noted. The number of doses to be given was not documented. The route was not documented. The form did not state if the drug should be administered immediately or if it could be postponed.</p> <p>The inhalation treatment with Duoneb was administered at 7:40 PM on 6/12/10, according to the MAR. The reason for the 2 hour and 23 minute delay was not documented.</p> <p>Staff B, the nurse on duty when Patient #7 was treated in the ER, was interviewed on 6/16/10 at 11:20 AM. She stated she did not see the order for the Duoneb. She stated if she had seen the order she would have administered it in a timely manner.</p> <p>The pharmacist was interviewed on 6/16/10 at 10:20 AM. He reviewed Patient #7's medical record and stated the failure to write a complete order and administer Duoneb in a timely manner</p>	{C 276}	<p>significant medication errors. This corrective action will be completed by 07/23/2010 and the Pharmacist will be responsible to ensure continued compliance by being responsible for scheduling the pharmacy review committee meeting and reviewing all medication error QMM's.</p> <p>3. A system has been developed to check for outdated medications on the nursing unit. Both nursing staff and pharmacy staff will check all areas of medication storage on the nursing unit for outdates on a routine basis. The policy for medication management has been updated to reflect the role of the pharmacy and the nursing staff, (please refer to policy "Medication Management", attached). This corrective action will be completed by 07/23/2010 and the Director of Nursing will be responsible to ensure continued compliance by reviewing the medication management forms submitted monthly by the nursing staff, and by doing random checks of medication storage areas for outdated medications.</p>		

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{C 276}	<p>Continued From page 21 constituted a medication error.</p> <p>c. A separate medical record documented Patient #7 returned to the ER on 6/14/10 at 2:47 PM complaining of shortness of breath and cough. The "EMERGENCY ROOM RECORD" stated Patient #7 received "Prednisone 40 mg 2 pills" at 3:15 PM. An order for the Prednisone was not documented in the medical record.</p> <p>The pharmacist was interviewed on 6/16/10 at 10:20 AM. He reviewed Patient #7's medical record and confirmed the medication error.</p> <p>The hospital failed to ensure complete orders were written and failed to provide medication to Patient #7 in a timely manner.</p> <p>d. Patient #4, a 56 year-old female was seen on 6/14/10 as an outpatient. There was a telephone order written by an RN on a Harms Memorial Hospital prescription pad for "Valium, 7 mg, IM". The outpatient record documented Patient #4 received Valium 7 mg at 4:20 PM. Patient #4's medical record did not contain a diagnosis or reason for the order. The record did not contain instructions to the nurse regarding how to monitor Patient #4 following the injection.</p> <p>A policy titled "TELEPHONE, VERBAL, AND WRITTEN ORDERS FOR MEDICATION," dated 5/15/10 included the criteria for orders to contain:</p> <p>"-Date and time the order is prescribed -The reason the drug was ordered for the patient"</p> <p>In an interview on 6/16/10 at 10:30 AM, the pharmacist reviewed Patient #4's medication order and stated it constituted a medication error.</p>	{C 276}	<p>4. The Pharmacy has written a policy to designate that the Pharmacist will be a member of the Pharmacy and Therapeutics committee, (please refer to policy Pharmacy and Therapeutics Committee, attached) and will attend medical staff meetings at least quarterly to formally communicate with the medical staff of the hospital. This policy will be implemented by 07/23/2010 and will be monitored by the CEO to ensure compliance.</p> <p>5. The Pharmacist has instituted a program of competency education and testing for nursing staff related to mixing and administering of IV medications. A policy has been written to address the mixing of IV medications (please refer to policy titled "IV Fluids with Additives Medications, Preparation and Administration, attached), and a policy has been developed to ensure the competency of nurses to mix and administer IV medications and solutions (please refer to policy</p>				

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{C 276}	<p>Continued From page 22</p> <p>e. Patient #5, an 88 year-old female was seen as an outpatient on 6/14/10 at 11:53 AM for left leg and hip pain. A verbal order was given to Staff H, a RN, by Patient #5's physician for Decadron and Toradol. The verbal order was not dated or timed, and was not signed by the physician.</p> <p>In an interview on 6/16/10 at 10:30 AM, the pharmacist reviewed Patient #5's medical record. He stated since the order was not dated, timed, or signed, it was a medication error.</p> <p>f. Patient #9 was a 58 year-old female, brought to the ER on 6/11/10 with severe pain in her right upper leg after falling from a horse. An entry was on the "ER PROVIDER ORDER AND DOCUMENTATION RECORD," that was undated, untimed and unsigned. It read "MS 4 mg X 2," followed by the name of Staff J, a NP, and the word "approved." Patient #9's record also documented IV fluids had been administered, although there was no order for the IV fluids.</p> <p>In an interview on 6/16/10 at 10:30 AM, the pharmacist reviewed Patient #9's medication order. He stated since the order was not dated, signed or timed, it was a medication error.</p> <p>g. Patient #12, a 16 year-old male came to the ER on 6/13/10 at 7:50 PM with severe sore throat pain. The "EMERGENCY ROOM RECORD" on page 2, dated 6/13/10, documented Patient #12 received a dose of Amoxicillin (an antibiotic) 1 gram at 8:05 PM. No medication order was documented.</p> <p>In an interview on 6/17/10 at 11:15 AM, the DON</p>	{C 276}	<p>titled "IV Competence and Personnel Monitoring", attached). An area of the nursing unit has been designated for the preparation of IV medications. A laminar hood has been ordered and will be installed in the designated area upon its arrival. Competency training was done for nursing staff on 07/08/2010 by the pharmacist, and all policies and training will be completed by 07/23/2010. The pharmacist will be responsible to ensure continued compliance with these corrective actions.</p>	

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{C 276}	<p>Continued From page 23</p> <p>reviewed the record of Patient #12 and confirmed the documentation of medication given. She confirmed the order was not complete.</p> <p>In an interview on 6/16/10 at 10:30 AM, the pharmacist reviewed Patient #12's medication order. He stated since the order was not dated, signed or timed, it was a medication error.</p> <p>h. Patient #14, a 42 year-old female came to the ER on 6/15/10 with the complaint of a right-sided headache for 2 hours. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD," had an order entry from Staff I, a NP, that was undated and untimed, for "Flexeril 10 mg PO Now," and "dispense Flexeril 10 mg X 2 tabs to take home."</p> <p>In an interview on 6/16/10 at 10:30 AM, the pharmacist reviewed Patient #14's medication order. He stated the since the order was not dated or timed, it was a medication error.</p> <p>i. Patient #15, a 12 year-old male came to the ER on 6/16/10 with a complaint of sore throat. The "ER PROVIDER ORDER AND DOCUMENTATION RECORD," had a verbal order entry from Staff I, a NP, that was undated and untimed, for "Azithromycin 200/5 ml-PO Now, give 5 ml, then dispense remainder of bottle with instructions to take 2.5 ml every day X 4 days." The record documented Staff I performed an assessment and spoke with Patient #15's mother.</p> <p>In an interview on 6/16/10 at 10:30 AM, the pharmacist reviewed Patient #15's medical record. He stated because the order was not dated or timed, it was a medication error.</p>	{C 276}			

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{C 276}	<p>Continued From page 24</p> <p>The CAH had 2 medication error policies. One was a pharmacy policy, dated 2/15/01, titled "Medication Error Policy and Procedure." It was a 1 page policy that stated "All medication errors that have the potential to cause an adverse reaction with the resident will be reported to the resident's physician or the physician on call in the Emergency Department in the absence of the primary physician within 24 hours." The policy did not define medication errors.</p> <p>Another policy, not dated, titled "MEDICATION ERRORS-EMERGENCY DEPARTMENT," defined 7 levels of medication errors and types of errors. It was not clear if this policy applied to the entire hospital.</p> <p>The CAH's policies were inconsistent and failed to prevent medication errors.</p> <p>2. The pharmacist was not involved in the monitoring and prevention of medication errors.</p> <p>The pharmacy policy "Medication Error Policy and Procedure," dated 2/15/01, stated all medication errors would be reported to the Compliance Officer and reviewed by the "Pharmacy Review Committee" on a monthly basis. The policy did not specify the pharmacist's role in reviewing medication errors.</p> <p>An Emergency Department policy titled "Medication Errors," not dated, stated significant medication error reports would be reviewed by the Pharmacy and Therapeutics Committee. It listed 7 levels of medication errors from potential errors up to and including patient death. The accompanying procedure did not specify a role for the pharmacist.</p>	{C 276}			

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{C 276}	<p>Continued From page 25</p> <p>The pharmacist was interviewed on 6/16/10 at 10:20 AM. He stated he did not review medication errors at the hospital.</p> <p>The DON was interviewed on 6/16/10 at 9:45 AM. She stated medication errors were reviewed by the Pharmacy Review Committee. She said she was not part of the committee. Upon further questioning, she stated the Pharmacy Review Committee was a nursing home committee and was not a committee for the hospital.</p> <p>3. A system had not been developed to check for outdated medications on the nursing unit. Surveyors observed the medication cart and storage area behind the nursing station on 6/17/10 beginning at 2:00 PM. Outdated medications which were observed included:</p> <ul style="list-style-type: none"> -medication cart- Ibuprofen 13 tablets, expired 1/2010 -storage area- Sodium Chloride vials, expired 5/2005 Epinephrine 1:1000 injectable, expired 5/01/2010 Benadryl injectable, expired 4/2010 Nexium injectable, expired 4/2010 <p>The "Consulting Agreement" for the pharmacist, signed on 1/09/1999, stated the pharmacist was to "Periodically check drugs and drug records in all locations in the hospital where drugs are stored, including but not limited to nursing stations, emergency room, outpatient departments, and operating suites."</p> <p>The pharmacist was interviewed on 6/16/10 at 10:20 AM. He stated nurses checked for outdated medications on the hospital units. He</p>	{C 276}			

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{C 276}	<p>Continued From page 26</p> <p>stated he did not know if there was a system in place to check for outdated medications not in the pharmacy.</p> <p>4. The CAH did not ensure the pharmacist participated with the medical staff to provide oversight of medication storage and delivery systems.</p> <p>The policy "Pharmacy and Therapeutics Committee," approved 3/12/03, stated the Pharmacy and Therapeutics Committee consisted of the pharmacist and a member of the medical staff and nursing staff as well as others. The policy stated the Pharmacy and Therapeutics Committee met monthly in conjunction with the Medical Staff meeting.</p> <p>Five monthly Medical Staff meeting minutes between 1/13/10 and 5/12/10 were reviewed. None of these minutes listed the pharmacist in attendance.</p> <p>The pharmacist was interviewed on 6/16/10 at 10:20 AM. He stated he was not a part of the Pharmacy and Therapeutics Committee. He stated he did not attend Pharmacy and Therapeutics Committee meetings or otherwise formally communicate with the medical staff at the hospital.</p> <p>5. The pharmacist did not provide oversight of IV medications and solutions stored and administered at the hospital.</p> <p>Nurses mixed most IV medications administered at the hospital. Review of ER and OP patient records documented administration of IV antibiotics to patients on a daily basis from</p>	{C 276}			

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{C 276}	<p>Continued From page 27</p> <p>6/11/10 to 6/16/10. IV medications documented as administered during that time included Solumedrol (a steroid), Levaquin (an antibiotic), Rocephin (an antibiotic), Toradol (a non-steroidal anti-inflammatory drug), Cubicin (an antibiotic), Invanz (an antibiotic), and Decadron (a steroid).</p> <p>Pharmacy policies did not address the mixing of IV medications. This was confirmed by interview with the pharmacist on 6/16/10 at 10:20 AM. He stated the DON had oversight of IV medications. He stated he was not involved with the mixing of IV medications.</p> <p>The DON was interviewed on 6/17/10 at 11:15 AM. She confirmed policies related to the mixing of IV medications had not been developed. She stated staff referred to Mosby's "2010 Intravenous Medications" book for technical assistance such as which IV solutions were incompatible with which medications. However, she said a policy to ensure the competency of nurses to mix and administer IV medications and solutions had not been developed. She stated the CAH did not have a written policy that included guidelines for preparing IV fluids and mixtures for ER, OP, and inpatient administration.</p> <p>The CAH maintained a small open medication storage and preparation room, approximately 5 feet wide by 6 feet long. In the room against one wall was a medication cart on wheels which was approximately 4 feet high, 2 feet wide, and 2 feet deep. At the opposite wall was a sink with a counter that ran the length of the wall. The counter held a large red bucket-type sharps container, a 4 tier open storage unit with syringes and wrapped supplies, several notebooks, and a small refrigerator for medications that needed to</p>	{C 276}			

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{C 276}	Continued From page 28 be kept cold. To the right of the wheeled medication cart was a wall mounted locked cabinet with 3 open shelves below it. The shelves held plastic buckets which contained various IV, oral, and topical medications. The medications were labeled, but contained no patient labels, and included both opened containers and unopened vials. The small "U" shaped room could accommodate only one staff member at a time. The open counter area for medication preparation was approximately 14 inches wide by 8 inches deep next to a hand washing sink and in front of the 4 tier open storage unit. In an interview with Staff B, the Charge Nurse on 6/17/10 at 3:30 PM, she explained the above described medication room was the room where all patient medications, IV's, and IV medications were prepared, which also included OP and ER patients. Staff B stated she thought the counter area of 8 inches by 14 inches was an adequate sized area for patient medication preparation. Staff B stated the open plastic buckets of opened and unopened medications without patient names was a stock medication supply to be used as needed, and charged to the patient when used. The pharmacist was interviewed on 6/16/10 at 10:20 AM. He stated he had not inspected the area to ensure it was adequate for the mixing of IV medications. IV medications at the CAH were not supported by pharmacist oversight or by CAH policies.	{C 276}			
{C 330}	485.641 PERIODIC EVALUATION & QA REVIEW Periodic Evaluation and Quality Assurance Review	{C 330}	C 330 485.641 PERIODIC EVALUATION & QA REVIEW Refer to C-336 as it relates to the failure of the CAH to ensure an effective quality assurance program had been developed and implemented.		23 July 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/18/2010
NAME OF PROVIDER OR SUPPLIER HARMS MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET AMERICAN FALLS, ID 83211		
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{C 330}	Continued From page 29	{C 330}			
	<p>This CONDITION is not met as evidenced by: Based on staff interview and review of hospital policies, QI meeting minutes and documents, emergency room registers, and past survey reports, it was determined the CAH failed to ensure a comprehensive Quality Assurance program had been put into effect. This resulted in the inability of the CAH to identify and correct care related issues. The findings include:</p> <p>Refer to C336 as it relates to the failure of the CAH to ensure an effective quality assurance program had been developed and implemented.</p> <p>The cumulative effect of these negative systemic practices resulted in the inability of the CAH to provide care of sufficient level or quality.</p>				
{C 336}	<p>485.641(b) QUALITY ASSURANCE</p> <p>The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that --</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policies, QI meeting minutes and documents, the emergency room register, and past survey reports, it was determined the CAH failed to ensure an effective quality assurance program had been developed and implemented. This resulted in the inability of the CAH to evaluate its</p>	{C 336}	<p>C 336 485.641(b) QUALITY ASSURANCE</p> <p>1. A revised Quality Improvement plan has been developed by the Quality Improvement Coordinator that will include a process to determine appropriate departmental Quality Improvement projects, goals of the quality improvement committee, and a process to review data received from Department managers. Department specific data such as</p>		23 July 10

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{C 336}	<p>Continued From page 30</p> <p>programs and make improvements. The findings include:</p> <p>1. The policy "Quality Improvement," dated 7/22/09, stated the hospital would develop a "...process for continuous quality improvement to evaluate the quality of treatment in the facility. This process will be facility wide, include all departments and contracted services, and will include:</p> <p>Ongoing monitoring and data collection; Problem prevention, identification and data analysis; Identification of corrective actions; Implementation of corrective actions; evaluation of corrective actions..."</p> <p>The "Quality Improvement" policy stated a quality improvement committee would meet at least quarterly to "a. Perform problem identification, assessment and facilitation of improvement activities. b. Coordinate/Integrate QI and compliance activities throughout the hospital. c. Review data received from Department managers." The policy stated the quality improvement coordinator was "Assisting Hospital departments in data collection, analysis and reporting."</p> <p>The QI Committee meeting minutes for 2010 included minutes dated 1/12/10 and 4/13/10. The minutes for both meetings stated the committee met and discussed quality projects. However, no data was discussed in the minutes. Also, no data was attached to the meeting minutes. Missing data included department specific data and incidents such as falls and medication errors.</p>	{C 336}	<p>falls and medication errors will be collected. Data collected by department managers will be reviewed in the meeting, and will be compared with data collected in the past in order to determine if systems are improving. A quality improvement meeting was held on 07/12/2010 where the new policy was discussed and where each department identified quality improvement goals. The corrective action will be implemented by 07/23/2010 and will be monitored by the Quality Improvement Coordinator and the facility board of directors for continued compliance.</p> <p>2. The quality improvement committee will meet on 07/13/2010 to review the findings of the survey. The Director for Performance Improvement for the Idaho Hospital Association will be present at the meeting to review the quality improvement plan and corrective measures taken to ensure the QI program is effective. The CEO and Governing Board have formed an operations committee, which is</p>	

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{C 336}	<p>Continued From page 31</p> <p>The QI Coordinator was interviewed on 6/15/10 at 2:30 PM. Surveyors requested a copy of the QI plan. She stated a specific QI plan listing quality indicators was not documented. She stated a review of the overall QI plan had not been completed in the past year. She also stated QI data was not available. She stated she was not able to compare data, including incidents, from the past with current data in order to determine if systems were improving.</p> <p>The QI program for the hospital was not supported by a plan and data.</p> <p>2. The CMS form 2567, dated 5/05/10, stated it was determined the hospital was not in compliance with the Condition of Participation for Periodic Evaluation and Quality Assurance Review (42 CFR Part 485.641) due to an inadequate QI program. The QI Coordinator was interviewed on 6/15/10 at 2:30 PM. She stated since the 5/05/10 survey, the QI Committee had not met to review the QI program. She stated the committee was scheduled to meet the following week. She stated she had met with individual members of the committee but she did not have documentation of this.</p> <p>The hospital failed to evaluate its QI program and take corrective action.</p> <p>3. The hospital had identified only 2 medication/prescription errors between 10/20/09 and 6/14/10, the start of the follow-up survey. Surveyors identified 10 medication/prescription errors between 6/11/10 and 6/17/10.</p> <p>The QI Coordinator was interviewed on 6/16/10 at 9:45 AM. She stated a system to actively search</p>	{C 336}	<p>comprised of 3 members of the Governing Board and the CEO, and the committee met 07/02/2010, where the results from the survey of 05/05/2010, the plan of correction for the survey of 05/05/2010 were both reviewed. The CEO also reviewed for the operations committee the results of the survey of 06/25/2010, and the tentative plan of correction. The operations committee met again on 07/13/2010 to further review the issues identified in the survey and the plan of correction. The operations committee will meet at least quarterly to oversee quality improvement activities of the facility. This corrective action will be complete by 07/23/2010 and the CEO will be responsible for scheduling meetings and ensuring they occur at least quarterly.</p> <p>3. The policy and procedure for Medication errors has been updated jointly by pharmacy and nursing to include a definition of what constitutes a medication error. The policy also contains the means that the facility will</p>		

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{C 336}	<p>Continued From page 32</p> <p>for medication errors had not been developed. She stated the pharmacy technician conducted some medical record reviews. She acknowledged the pharmacy technician did not have a medical background and had not been trained to identify medication errors.</p> <p>The hospital failed to develop and implement an effective system to identify medication errors.</p> <p>4. The CAH had not developed a system to review cases where an RN conducted the medical screening examination. Occasionally, patients presented to the ER and were examined by an RN instead of another provider. The "EMERGENCY ROOM REGISTER" identified a patient who had presented to the ER on 6/14/10 at 7:47 PM complaining of nausea, vomiting, and diarrhea for the past 5 days. The register stated the patient had been examined by an RN and was discharged home at 8:11 PM.</p> <p>The Chief of the Medical Staff was interviewed on 6/22/10 at 10:20 AM. He stated a system had not been developed to ensure the cases of patients who were not examined by a physician or mid-level practitioner were reviewed in order to determine if they received an examination that was adequate to identify emergency medical conditions.</p> <p>The hospital failed to develop systems to review the cases of ER patients who were not examined by physician or mid-level practitioners.</p>	{C 336}	<p>employ to monitor for medication errors, (please refer to policy "Medication Errors", attached). By following the policy the facility will be able to find medication errors and provide education and counseling for staff committing errors, to better prevent them in the future. All nursing and pharmacy staff was in-serviced regarding the policy, and the need to generate a QMM incident report when discovering a medication error, on 07/15/2010 by the Director of Nursing. This corrective action will be completed by 07/23/2010 and the Director of Nursing will be responsible to ensure continued compliance by ensuring that chart audits of 100% of charts are done, that 24 hour chart checks are done daily, and that the pharmacy check the nursing drawer of medication against their MAR daily.</p> <p>4. The policy regarding RN's conducting Medical Screening Exams (MSE) has been updated to include the requirement that all charts where the RN conducted the MSE will be</p>	

STATE

SURVEY

REPORT

Bureau of Facility Standards

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{B 000}	<p>16.03.14 Initial Comments</p> <p>The following deficiencies were cited during the follow up survey to the state licensure survey of your CAH that was conducted on 5/05/10. Surveyors conducting the re-visit were:</p> <p>Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS</p> <p>The following acronyms were used in the survey report:</p> <p>CAH = Critical Access Hospital CEO = Chief Executive Officer CFR = Code of Federal Regulations CMS = Centers for Medicare and Medicaid Services DON = Director of Nursing Duoneb = a combination of 2 medications used during an inhalation treatment to treat difficulty breathing ER = emergency room GI = gastrointestinal gm = gram HIM = Health Information Management IDAPA = Idaho Administrative Procedures Act IM = intramuscular IV = intravenous mg = milligram ml = milliliter MS = Morphine Sulfate NP = nurse practitioner OP = outpatient PO = orally PRN = as needed QI = quality improvement RN = registered nurse TID = three times a day X = times</p>	{B 000}	<p>RECEIVED</p> <p>JUL 19 2010</p> <p>FACILITY STANDARDS</p>	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

8899

ZY1L12

TITLE

CEO/ADMINISTRATOR

(X6) DATE

14 JULY 2010

If continuation sheet 1 of 7

Bureau of Facility Standards

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{B 000}	Continued From page 1	{B 000}		
	The following deficiencies were cited during the licensure survey of your Critical Access Hospital and the Swing bed unit. Surveyors conducting the survey were: Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS			
{BB115}	16.03.14.200.01 Governing Body and Administration 200. GOVERNING BODY AND ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88) 01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code, community responsibility, and identify the purposes of the hospital and which specify at least the following: (10-14-88) a. Membership of Governing Body, which consist of: (12-31-91) i. Basis of selecting members, term of office, and duties; and. (10-14-88) ii. Designation of officers, terms of office, and duties. (10-14-88) b. Meetings, (12-31-91) i. Specify frequency of meetings. (10-14-88) ii. Meet at regular intervals, and there is an	{BB115}	BB 115 16.03.14.200.01 GOVERNING BODY AND ADMINISTRATION Please refer to the corrective action for federal citation C-241 as it relates to the hospital's failure to ensure the Governing Body assumed responsibility for the development and monitoring of hospital systems to ensure patients received safe and effective care. Also, please refer to the corrective action for federal citation C-240 as it relates to the Governing Body's failure to ensure it had developed and maintained an effective organizational structure.	23 JULY 10

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{BB115}	Continued From page 2 attendance requirement. (10-14-88) iii. Minutes of all governing body meetings shall be maintained. (10-14-88) c. Committees, (12-31-91) i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88) ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88) d. Medical Staff Appointments and Reappointments; (12-31-91) i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88) ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges. (10-14-88) iii. The procedure for appointment and reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually. (10-14-88) iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtailment of	{BB115}			

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{BB115}	Continued From page 3 privileges, and delineation of privileges. (10-14-88) v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88) vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. (10-14-88) e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88) f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. (10-14-88) g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88) h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88) i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88) j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88) k. The governing body shall appoint a chief	{BB115}		

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{BB115}	Continued From page 4 executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. (10-14-88) l. Bylaws shall be dated and signed by the current governing body. (10-14-88) m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88) This Rule is not met as evidenced by: Refer to C-241 as it relates to the hospital's failure to ensure the Governing Body assumed responsibility for the development and monitoring of hospital systems to ensure patients received safe and effective care. Refer to C-240 as it relates to the Governing Body's failure to ensure it had developed and maintained an effective organizational structure.	{BB115}		
{BB124}	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: Refer to C-336 as it relates to the failure of the hospital to develop and implement systems to	{BB124}	BB 124 16.03.14.200.10 QUALITY ASSURANCE Please refer to the corrective action for federal citation C-336 as it relates to the failure of the hospital to develop and implement systems to evaluate care provided to patients. Also, please refer to the corrective action for federal citation C-240 as it relates to the Governing Body's failure to ensure it	23 July 10

Bureau of Facility Standards
STATE FORM

Bureau of Facility Standards

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{BB221}	<p>Continued From page 6</p> <p>director of pharmaceutical services. (10-14-88)</p> <p>e. The director of the pharmaceutical service shall be responsible for maintaining records of the transactions of the pharmacy as required by law and as necessary to maintain adequate control and accountability of all drugs. This includes a system of control and records for the requisitioning and dispensing of drugs and supplies to nursing units and to other department/services of the hospital, as well as records of all prescription drugs dispensed to the patient. (10-14-88)</p> <p>f. The pharmacist shall periodically check drugs and drug records in all locations in the hospital where drugs are stored, including but not limited to nursing stations, emergency rooms, outpatient departments, operating suites. (10-14-88)</p> <p>This Rule is not met as evidenced by: Refer to C-276 as it relates to the hospital's failure to oversee the storage and administration of medications in accordance with accepted standards of practice.</p>	{BB221}			

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

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PS Form 3811, February 2004

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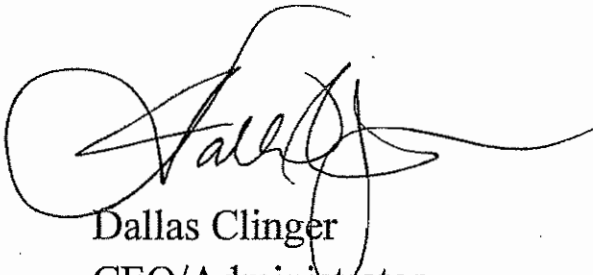


DO NOT REMOVE

July 7, 2010

EFFECTIVE IMMEDIATELY

Kris Babb has not renewed her certificate to prescribe scheduled medications, therefore, when she is covering the emergency department and has a patient that requires a prescription for a scheduled drug, Kris will call the backup doctor and inform him of the recommendation and then she will hand the telephone to the RN on duty for the backup doctor to make a telephone order. This procedure will take effect immediately and continue until her certificate has been renewed.

A handwritten signature in black ink, appearing to read 'Dallas Clinger', with a large, stylized initial 'D' and a long horizontal flourish extending to the right.

Dallas Clinger

CEO/Administrator

Harms Memorial Hospital District

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: **Emergency Treatment
And Transfer per EMTALA**

EFFECTIVE DATE: 7/14/2010

DEPARTMENT: Acute Nursing

SUPERSEDES P&P DATED: 2009

AUTHOR: Alice Taylor RN

DATE: 06/23/2010

APPROVALS:

Alice Taylor RN
Department Manager

7/14/10
Date

[Signature]
Administration

14 JULY 2010
Date

Board of Directors

Date

Dean L. Williams, MD
Medical Staff

7-14-10
Date

POLICY:

All patients presenting to the Emergency Room will be given a Medical Screening Examination by Qualified Medical personnel and will be stabilized or appropriately transferred to another facility.

PROCEDURE:

All patients presenting to the emergency department will have a Medical Screening Examination (MSE), including appropriate vital signs, performed and charted by Qualified Medical Personnel (QMP), which includes MD, DO, PA, FNP or RN, assisted as needed by other personnel. All RN's who are performing the Medical Screening Examination will be credentialed by the Human Resources department to ensure they have had the requisite training to perform the Medical Screening Examination. The nurse on duty at the Emergency Department will notify the on-call provider and provide him/her with the results of the MSE. The nurse, in consultation with the on-call provider, will determine if an emergency condition exists. The nurse that sees the patient at the hospital will have the ultimate authority to determine if the on-call provider must see the patient in the emergency department, or if the provider may defer the patient to normal clinic business hours. The on-call provider, upon receiving a call from the emergency department QMP, accepts full liability for determination of medical emergency. All patient's who received a MSE from an RN will have their charts reviewed by the provider who was on-call at the time the screening was performed to assess the appropriateness of the RN's medical screening exam. In

the event the on-call provider was a mid-level provider, the chart will be further reviewed by the mid-level providers supervising physician.

If a medical emergency is determined to exist, the patient will be stabilized and appropriate arrangement made for transfer to another facility. The patient must consent to a transfer or the provider must certify that the benefits of transfer outweigh the risks. The patient or provider must complete the Patient Request to Transfer form. The receiving facility must be contacted in advance to authorize the transfer. The patient must be provided with appropriate treatment to minimize risks during transfer, including the use of appropriate transfer equipment and accompanying staff as necessary. All medical records will accompany the patient to the receiving facility.

Emergency Treatment P&P.doc

Attachment: Patient request to Transfer Form

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: MEDICATION MANAGEMENT

EFFECTIVE DATE: 07/15/2010

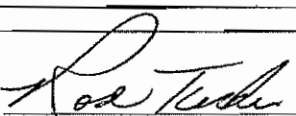
DEPARTMENT: ACUTE CARE/PHARMACY

SUPERSEDES P&P DATED: 2001

AUTHOR: ALICE TAYLOR R.N.

DATE: 07/08/2010

APPROVALS:


Department Manager


Date


Administration


Date

Board of Directors

Date


Medical Staff


Date

POLICY:

The organization has a process to identify expired medication, to establish minimum stock levels on the nursing floor, and to ensure that multi-dose medications are labeled appropriately when opened.

PROCEDURE:

- The medication storage areas are to be inspected monthly; the ICU medication cabinet, the hospital medication cabinet, and the ICU and ER crash carts.
- One nurse per month will be assigned to inspect one of the three areas.
- Medications stored in the ICU, hospital and crash carts will be established by the pharmacy and therapeutics committee and be approved by the medical staff.
- Minimum stock levels for medications in the ICU, hospital and crash carts will be established by the pharmacy and therapeutics committee.
- The nurse will use the Medication Management checklists to identify what the medications are, the correct number of medications, whether the medication is in

date, whether the medication is labeled appropriately, and what corrective action the nurse took to rectify any problems found.

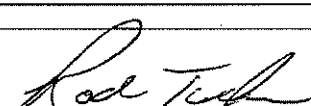
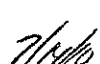
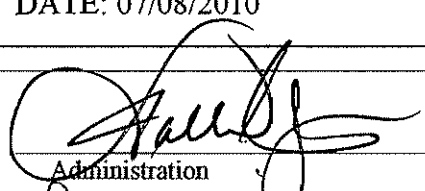
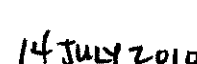
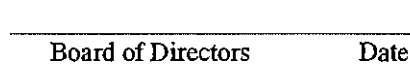
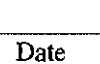
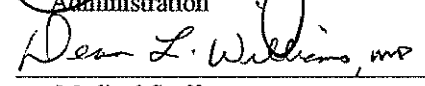
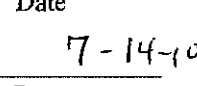
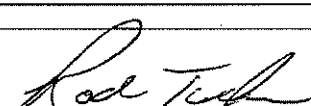
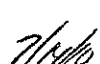
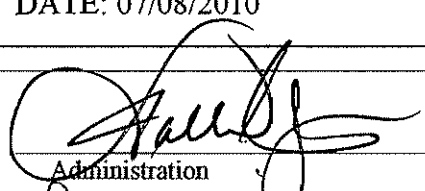
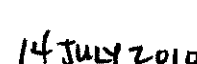
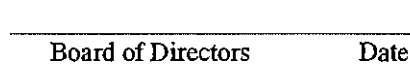
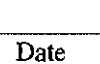
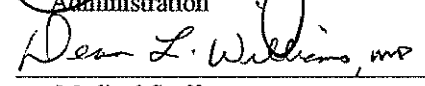
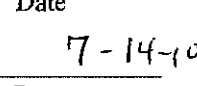
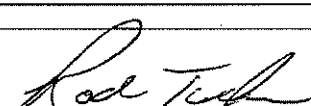
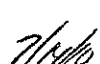
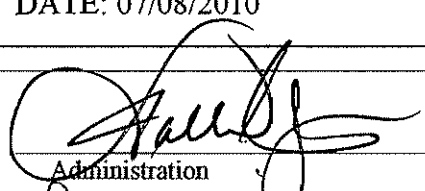
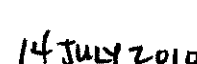
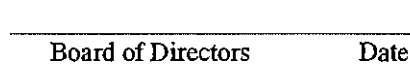
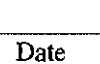
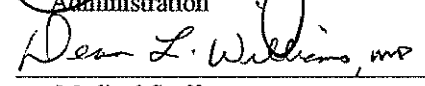
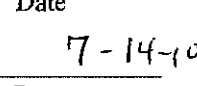
- The nurse will look through the cabinets or the crash cart and count all medications, inspect the expiration date of the medication, and note if opened multi-dose vials have been labeled to show the date opened.
- If the stock of medication is below the minimum stock level indicated, the medication will be obtained from pharmacy to meet the minimum stock level.
- Any medication that is expired or within one month of its expiration date will be pulled and sent to pharmacy with a request for replacement stock with a later expiration date.
- Any multi-dose vial that has been opened will be checked for a label indicating date opened. All multi-dose vials that have been open longer than 28 days will be discarded.
- All multi-dose vials that have been opened but have no label to indicate the date opened will be discarded.
- The nurse must notify the pharmacy of medications that have been discarded to ensure they are replaced, to maintain minimum stock levels.
- Medication management checklists will be submitted to the nurse manager upon completion.
- To further ensure medications are within the guidelines of this policy, the Pharmacist or Pharmacy Technician will check all medication storage areas identified in this policy one time each quarter. The Pharmacist or Pharmacy Technician will follow the same guidelines for checking the medications as indicated in this policy.

POLICY AND PROCEDURE

- A. The Pharmacist will attend quarterly
 - B. Pharmacy Technician
 - C. A member of the medical staff
 - D. A member of the nursing staff
 - E. A member of administration
 - F. A member of the infection control committee
 - G. A member of quality assurance committee
2. The pharmacy and therapeutics committee will only meet at the medical staff meetings and be part of the meeting.
3. The purposes of the Pharmacy and Therapeutics committee will be to:
Approve the hospital formulary for Harms Memorial Hospital.
 - A. Approve changes to the hospital formulary for Harms Memorial Hospital.
 - B. Consider new drugs.
 - C. Review reports of medication errors.
 - D. Review medication usage studies.
 - E. Review medication quality assurance issues including medication errors.

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: PHARMACY ACCESS MEDICATION TRACKING		EFFECTIVE DATE: 07/15/2010											
DEPARTMENT: PHARMACY/HOSPITAL		SUPERSEDES P&P DATED: 2001											
AUTHOR: ALICE TAYLOR R.N.		DATE: 07/08/2010											
<table style="width: 100%; border: none;"><tr><td style="width: 25%; vertical-align: top;">APPROVALS:</td><td style="width: 25%; text-align: center; vertical-align: bottom;"> _____ Department Manager</td><td style="width: 10%; text-align: center; vertical-align: bottom;"> _____ Date</td><td style="width: 40%; text-align: center; vertical-align: bottom;"> _____ Administration</td><td style="width: 10%; text-align: center; vertical-align: bottom;"> _____ Date</td></tr><tr><td></td><td style="text-align: center; vertical-align: bottom;"> _____ Board of Directors</td><td style="text-align: center; vertical-align: bottom;"> _____ Date</td><td style="text-align: center; vertical-align: bottom;"> _____ Medical Staff</td><td style="text-align: center; vertical-align: bottom;"> _____ Date</td></tr></table>				APPROVALS:	 _____ Department Manager	 _____ Date	 _____ Administration	 _____ Date		 _____ Board of Directors	 _____ Date	 _____ Medical Staff	 _____ Date
APPROVALS:	 _____ Department Manager	 _____ Date	 _____ Administration	 _____ Date									
	 _____ Board of Directors	 _____ Date	 _____ Medical Staff	 _____ Date									

POLICY:

To assure security and control of distribution of pharmaceuticals, access to the pharmacy is limited to the pharmacist and RN Supervisor. The Pharmacy Technician may enter with the Pharmacist or RN Supervisor present. All medications removed from the pharmacy will be accounted for to ensure proper distribution.

PROCEDURE:

1. In the absence of the Pharmacist, the hospital RN may enter the pharmacy to fill new medication orders. All medication removed from the pharmacy must be noted on the tracking form. Required information includes:
 - Date
 - Time
 - Patient/Resident Name
 - Patient/Resident location
 - RN initials
 - Drug name
 - Quantity of medication removed
 - Quantity of medication used

- Quantity of medication returned to the pharmacy
 - Why the medication was not used
2. The Pharmacist or Pharmacy Technician will check the Medication check out for each workday and account for all medications taken out of the pharmacy.
 3. The Pharmacist or Pharmacy Technician will document on the Medication Check out Sheet whether the medication was used, returned to the pharmacy or why the medication was not given.
 4. During chart audits the Pharmacy Technician will note medications used and compare to those removed from the pharmacy to ensure all medications used were checked out of the Pharmacy on the Medication Checkout List.
 5. In the event there is a discrepancy between the medication checked out of the pharmacy and the medication used, the Pharmacy technician will attempt to account for the medication. If the medication cannot be accounted for the Pharmacy Technician will generate a Quality Management Memo (QMM) and submit it to the department supervisor for investigation.
 6. In the event the Pharmacy Technician discovers medication that was removed from the pharmacy without being checked out on the Medication Checkout List, the Pharmacist or Pharmacy Technician will generate a QMM and submit it to the department supervisor for investigation.

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: MEDICATION ERRORS

EFFECTIVE DATE: 07/15/2010

DEPARTMENT: FACILITY WIDE

SUPERSEDES P&P DATED: 2001

AUTHOR: ALICE TAYLOR R.N.

DATE: 07/08/2010

APPROVALS:

Rod Tush
Department Manager

7/14/10
Date

[Signature]
Administration

14 JULY 2010
Date

Board of Directors

Date

Dean L. Williams, MD
Medical Staff

7-14-10
Date

POLICY:

The organization has a process to respond to actual or potential medication errors. All actual or potential errors identified will be documented through the hospital's risk management system. All medication error reports will be reviewed by the pharmacy review committee. All adverse medication events requiring notification through external state, federal, USP or FDA channels, will be reported according to the requirements of the specific organization.

DEFINITIONS:

- Significant medication errors are those which require medical intervention and/or result in possible or confirmed morbidity or mortality.
 - Level 0 No error occurred, potential error (near miss)
 - Level 1 Error occurred without harm to patient
 - Level 2 Error occurred, increase monitoring but no change in vital signs or any patient harm
 - Level 3 Error resulted in need for increased monitoring, there was change in vital signs but no ultimate patient harm; any error needing increased laboratory monitoring

- Level 4 Error resulted in need for treatment with another drug, increased length of stay, patient transfer to a higher level of care (i.e., ICU) or required intervention to prevent permanent impairment or damage
- Level 5 Error resulted in permanent patient harm
- Level 6 Error resulted in patient death
- Types of medication errors include:
 - Wrong: drug, dose, route or time.
 - Omission (not administered before next schedule dose due).
 - Unordered dose.
 - Medications given greater than one hour prior to the time ordered or greater than one hour later than the time ordered.
 - Failure to document medication was given.
 - Failure to document verbal or telephone orders.
 - Failure to transcribe verbal or telephone orders in the proper format, as outlined in the policy for "Telephone, Verbal and Written Orders for Medication".

PROCEDURE:

- When a medication error occurs the following should occur in this order:
 - Notify the physician and evaluate the patient.
 - Perform any necessary clinical interventions, within the patient care provider's scope of practice to reduce the negative effects of the identified error.
 - Record the medication as given in the medical record.
 - Record the observed and assessed outcome of the patient in the medical record.
 - Record notification of physician in the medical record with any resultant orders.

- Record any actions and clinical interventions taken and the patient's response to same.
- The practitioner who identifies an error will initiate and document all relevant particulars on a Quality Management Memo (QMM).
- QMM reports will be submitted directly to the unit manager or if after hours will be placed in the QMM box.
- All QMM reports of medication error will be reviewed by the pharmacy review committee and categorized according to severity, type, and cause.
- All QMM medication error reports evaluated as significant (Level 4 or above) will be referred the Pharmacy and Therapeutics Committee.
- The Pharmacy Review Committee will determine necessary interventions to prevent medication errors, such as staff education and competency training.
- The pharmacist will be responsible to perform education and competency training for staff related to medication administration, if necessary, based on the monthly review of medication errors.
- Summary data and trend analysis will be performed by the pharmacy review committee. Reports of actions taken and appropriate follow-up will be made to the Pharmacy and Therapeutics Committee.

PROCEDURE FOR IDENTIFYING MEDICATION ERRORS:

1. The pharmacist or pharmacy technician will review all Emergency Department and Outpatient Department charts daily and list all medications used during these patient visits.
2. The Pharmacist or Pharmacy Technician will reconcile all medications taken from the pharmacy against any medications used in the ED, OP, or Inpatient departments and ensure that all medications were signed out of the pharmacy following the proper procedure. If it is determined that a medication was taken from the pharmacy without following the procedure the Pharmacist or Pharmacy Technician will generate a Quality Management Memo (QMM).
3. All ED and OP charts will be reviewed by the Pharmacist or Pharmacy Technician, and the Director of Nursing, to ensure that all medications given are accompanied by an order, which has been written in the correct format as described in the policy "Telephone, Written and Verbal Orders for Medication". If an order for a medication is missing or written in an incorrect format the Pharmacist, Pharmacy Technician, or the DON will generate a QMM.
4. Nursing staff will perform a 24 hour chart review once daily. The nurse will check all inpatient and swing bed charts for orders being noted; all new orders

were transcribed correctly to the MAR; telephone, written and verbal orders are in the proper format; that all medications on the MAR were initialed as having been given, and if not given the reason is documented; that all lab and x-ray orders were ordered and completed. If, in the course of this review, the nurse performing the 24 hour check finds an error, a QMM will be initiated.

5. All inpatient and swingbed patients will have an MAR at the nurses station for the nursing staff documentation, and an MAR in the pharmacy for the pharmacy documentation. The Pharmacist or pharmacy technician will fill the medication drawers for all inpatient and swing bed patients daily referring to the pharmacy MAR. When the drawers are switched the pharmacist or pharmacy technician will examine the contents of the used drawer. If there are any medications left in the drawer that should have been given the Pharmacist or pharmacy technician will generate a QMM.
6. The Director of Nursing for Harm's Memorial will perform random chart audits, checking for medication errors. The DON will generate a QMM upon the discovery of any medication errors.

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: Providers with Restricted Licenses

EFFECTIVE DATE: 08/01/2010

DEPARTMENT: Human Resources

SUPERSEDES P&P DATED: New Policy

AUTHOR: Norma Hartley

DATE: 06/30/2010

APPROVALS:


Department Manager

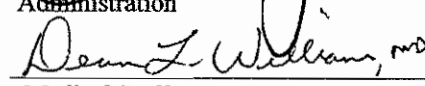
7-14-10
Date

Board of Directors

Date


Administration

14 JULY 2010
Date


Medical Staff

7-14-10
Date

POLICY STATEMENT: Generally a license to practice medicine; or a license to practice any of the healing arts is issued by the state of Idaho to an individual without limitations. None of the licensing boards examines the skills needed to perform any procedure nor the individual qualifications for certain types of practice.

It is the role of the hospital or credentialing agency to determine particular qualifications of each practitioner and to consider the unique circumstances of the environment of care they offer.

This policy is drafted to address the fact that certain providers may, by virtue of the fact that their behaviors, have come to the attention of their licensing board, will in fact have limitations imposed on certain aspects of their practice. See Section 54-1814 Idaho Code.

Procedure:

1. As a condition of admission to the medical staff at Harms Memorial Hospital each applicant will be required to disclose whether or not there is at the time any restriction currently imposed on their practice by any licensing agency.
2. As a condition of admission to the medical staff at Harms Memorial Hospital each applicant will be required to disclose whether or not there has ever been any restriction imposed on their license by any licensing agency.
3. If restrictions have been or are currently imposed, the governing body of Harms Memorial Hospital will consider the circumstances of those restrictions and use this information in granting or refusing privileges.

**Harms Memorial Hospital District
Providers with Restricted Licenses Policy and Procedure**

Procedure continued:

4. After considering any restrictions imposed by any agency, the governing body of Harms Memorial Hospital may grant the requesting practitioner limited or restricted privileges.
5. If limited or restricted privileges are granted such will be noted in the practitioners credentialing file, and the practitioner will acknowledge in writing those restrictions.
6. Further, the practitioner will acknowledge in writing, the fact that any violations of restrictions imposed may be grounds for immediate termination of all privileges.

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: IV FLUIDS WITH ADDITIVES
MEDICATIONS: PREPARATION
AND ADMINISTRATION

EFFECTIVE DATE: 07/15/2010

DEPARTMENT: ACUTE CARE/PHARMACY SUPERSEDES P&P DATED: 2001

AUTHOR: ALICE TAYLOR R.N.

DATE: 07/08/2010

APPROVALS:

Pharmacy

Date

Administration

Date

Board of Directors

Date

Medical Staff

Date

POLICY:

- Continuous and intermittent IV medication infusions should be infused via an infusion pump. Specific documentation is required on the MAR or infusion record.
- Aseptic technique must be used in preparation of all parenteral fluid/medication infusions.
- A filter needle must be used when withdrawing medication from a glass ampule. The filter needle should be replaced with the appropriate device prior to administration of the prescribed medication.
- When adding or mixing a medication for intravenous administration, the procedure must take place in a designated admix area. The admix area is a dedicated space for the mixing and/or addition of medications to intravenous solutions. This area should be free of any clutter and wiped down prior to use. The nurse mixing or adding the medication shall be undisturbed while performing this task.

REFERENCE :

The most recent edition of the following reference manuals will be kept at the Nursing station to consult when mixing Intravenous medications:

- Gahart, Betty L., and Nazareno, Adrienne R., Intravenous Medications, Mosby, St. Louis, Missouri
- Lippincott, Williams and Wilkins, Nursing Drug Handbook, Walters Kluwer, NY, NY
- The Physicians Drug Reference
- Package insert of the medication to be mixed

Nursing staff should always consult the facility pharmacist if there is any question regarding mixing of IV medications.

Portneuf Medical Center pharmacy department may be contacted for questions related to mixing of IV medication. HMHD has an affiliation agreement with PRMC to be a consulting hospital which includes providing this service.

Names and telephone numbers of our facility pharmacist, and the pharmacist at Portneuf Medical Center will be displayed at the nurses station, for use if any question arises regarding the mixing or administration of any IV medication.

PROCEDURE:

A. Nursing Procedures for Preparation of IV Admixtures for Medication

1. Any IV solution that is mixed outside of a Laminar flow hood will be changed within 12 hours.
2. Administration must begin within one hour.
3. Check compatibility chart or resource on the unit to ensure the safe infusion of the medication.
4. Check order and transcribe onto MAR/IV infusion record.
5. Check that the IV solution chosen is the correct solution and that the solution has not expired.
6. Inspect bag and/or bottle for leaks and/or particulate matter.
7. Scrub hands and wrists with approved hand hygiene product.

B. Preparation of Medications:

1. Withdrawal of contents of ampules:
 - a. Tap ampule gently while in the upright position to release solution that may be trapped in the stem above the neck.
 - b. Wipe neck of ampule with an alcohol swab and allow to air dry.

- c. Wrap swab around top of ampule to avoid cuts if ampule breaks, and snap off the neck of the ampule.
 - d. Inspect the opened ampule for glass particles.
 - e. Attach filter needle to syringe. If air is present in syringe, remove it.
 - f. Tilt ampule, submerge needle into solution, and avoid touching the outside rim of the ampule with the needle.
 - g. DO NOT draw solution from the bottom of the ampule; this will prevent aspiration of glass particles.
 - h. Remove filter needle prior to injecting drug into bag.
2. Reconstituting Drugs/Withdrawal of Contents from Vial:
- a. Draw up the amount and type of diluent specified by the manufacturer.
 - b. Remove dust cover over rubber stopper and discard.
 - c. Clean stopper with an alcohol swab using aseptic technique and allow to air dry.
 - d. Avoid excess alcohol and lint as they may be carried with the needle into the vial.
 - e. Place vial on flat surface, with the rubber closure at the top.
 - f. Penetrate the rubber closure with the needle, beveled edge up, at an angle of 45 to 60 degrees.
 - g. As the closure is penetrated, elevate the needle to a vertical position to minimize coring or breaking off of rubber pieces, which would then float inside the vial.
 - h. Inject the diluent. Avoid bubbling air through the solution.
 - i. Mix thoroughly by gently inverting the vial.
 - If the drug does not dissolve within a few seconds, let it stand for 10 to 30 minutes.
 - If necessary invert the vial several times to dissolve the drug.
 - Do not shake vigorously (unless directed) because some drugs may froth.
 - j. Withdraw the medication from the vial using aseptic technique.
 - k. With the syringe and needle held upward, tap the syringe to allow air bubbles to surface. Remove air bubbles.
 - l. Read volume of solution by aligning rubber end of plunger with calibration markings on the barrel of the syringe.
3. Diluting Liquid Drugs:
- a. Liquid drugs do not need reconstitution, but they often require dilution.
 - b. When diluting a drug, remember that all liquid drug containers are overfilled. Be sure to withdraw only the prescribed amount.
4. Using Specialized Containers (drugs that come in double-chambered vials that contain powder in the lower chamber and a diluent in the upper one).
- a. To combine these contents, apply pressure to the rubber stopper on top of the vial to dislodge the rubber plug separating the compartments.
 - b. Mix the diluent with the drug in the bottom chamber.

5. Adding Drug to IV Bags:

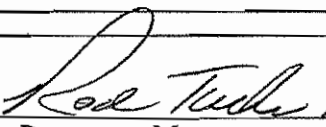
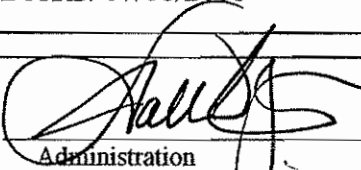
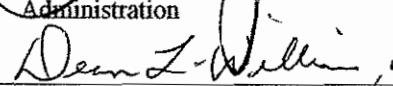
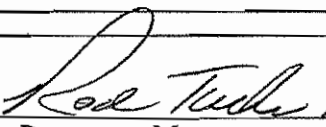
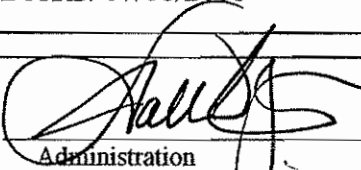
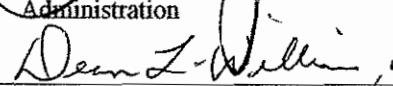
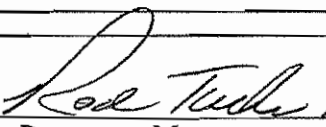
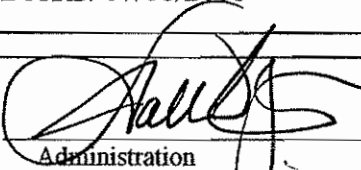
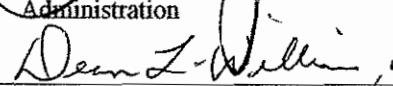
- a. Validate calculations with a peer. If there is any doubt with the mixing or calculations of the IV mixture, discard the solution and start again.
- b. Swab the injection port with alcohol wipe and allow to air dry.
- c. The needle should be at least 19G or 20G and be 1" long to penetrate the inner seal of the port on an IV bag.
- d. Inject medication into the IV solution.
- e. After injecting the drug, grasp the top and bottom of the bag and quickly invert it twice. Do not squeeze or shake the bag.
- f. Check all solutions (before and after mixing) against a well-lit background for particulate matter.
- g. After reconstitution, again check for visible signs of incompatibility in admixture.
 - Incompatibility is more likely with drugs or IV solutions that have a high or low pH.
 - Most drugs are moderately acidic, but some are alkaline, including heparin, aminophylline, ampicillin sodium, and sodium bicarbonate.

C. Labeling Solution Containers:

1. Containers prepared outside of the pharmacy will have a clearly legible standardized orange or red label showing:
 - Initials of the person preparing the mixture
 - Patients name
 - Date and time mixed
 - Room number
 - Name and amount of drug added to solution
2. Label should not cover the manufacturer's label.

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: IV COMPETANCE AND PERSONNEL MONITORING		EFFECTIVE DATE: 07/15/2010									
DEPARTMENT: PHARMACY/ACUTE CARE		SUPERSEDES P&P DATED: 2001									
AUTHOR: ALICE TAYLOR R.N.		DATE: 07/08/2010									
<table style="width: 100%; border: none;"><tr><td style="width: 25%; vertical-align: top;">APPROVALS:</td><td style="width: 25%; text-align: center; vertical-align: bottom;"> _____ Department Manager</td><td style="width: 25%; text-align: center; vertical-align: bottom;"> _____ Administration</td><td style="width: 25%; text-align: center; vertical-align: bottom;">14 JULY 2010 _____ Date</td></tr><tr><td></td><td style="text-align: center; vertical-align: bottom;">_____ Board of Directors</td><td style="text-align: center; vertical-align: bottom;"> _____ Medical Staff</td><td style="text-align: center; vertical-align: bottom;">7-14-10 _____ Date</td></tr></table>				APPROVALS:	 _____ Department Manager	 _____ Administration	14 JULY 2010 _____ Date		_____ Board of Directors	 _____ Medical Staff	7-14-10 _____ Date
APPROVALS:	 _____ Department Manager	 _____ Administration	14 JULY 2010 _____ Date								
	_____ Board of Directors	 _____ Medical Staff	7-14-10 _____ Date								

POLICY:

Nursing staff will be trained and competent to mix and administer IV medications. All personnel compounding sterile preparations must successfully complete training in aseptic techniques and aseptic area practices prior to preparing CSP's.

PROCEDURE:

The Pharmacist will:

- Conduct yearly training before July 1 of each year with all Acute Care Nursing staff on aseptic technique and aseptic area practices.
- The training will include education, a formal written test, and practical return demonstration of techniques.
- Conduct ongoing Quality Assurance to include media fill test and surface sampling.
- Provide re-education and training on an as needed basis based on the results of the Quality Assurance data.

Personnel who compound CSP's must:

- Pass written tests of basic and compounding knowledge.
- Appropriately perform hand hygiene.
- Clean the compounding areas.
- Perform aseptic technique for every type of preparation compounded in the facility.
- Properly use equipment
- Successfully complete a media fill test.
- Demonstrate that surfaces are clean using surface sampling techniques.

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: QUALITY IMPROVEMENT PLAN

EFFECTIVE DATE: 07/15/2010

DEPARTMENT: FACILITY WIDE

SUPERSEDES P&P DATED: N/A

AUTHOR: ALICE TAYLOR R.N.

DATE: 07/12/2010

APPROVALS:

Alice Taylor
Department Manager

7-15-10
Date

Dean L. Williams, MD
Administration

14 July 2010
Date

Board of Directors

Date

Medical Staff

7-14-10
Date

PURPOSE:

Harm's Memorial Hospital District (HMHD) is committed to providing quality health care that recognizes the worth and dignity of all persons, and to offer services that operate in an ethically and fiscally responsible way without compromising the patient and patient care needs.

Our goal is to provide care that is safe, effective, patient centered, timely, efficient and equitable. To achieve this goal all employees will participate in ongoing and systematic quality improvement efforts.

Our Quality Improvement Plan demonstrates HMHD commitment to improve the quality of care that we deliver. The QI plan outlines the goals and strategies for ensuring patient safety, delivering optimal care, and achieving high patient satisfaction.

AUTHORITY:

The Governing Board of HMHD is ultimately responsible for assuring that high quality care is provided to our patients. The Board delegates the responsibility for implementing this plan to the Medical Staff, the Quality Improvement Committee, and to the hospital's operations committee.

Medical Staff responsibility:

The medical staff at HMHD participates in medical record review, review of transfers to other facilities, credentialing, and PEER review. The ultimate goal is to improve the quality of care that is routinely provided to the patients of HMHD.

Department Staff Responsibility:

Every department in HMHD is responsible for implementing quality improvement activities. All quality improvement initiatives must be conducted as a part of the hospital wide Quality Improvement Committee activities. Each department manager is responsible for identifying quality indicators, collecting and analyzing data, developing and implementing changes to improve service delivery, and monitoring to assure that improvement is made and sustained. The ultimate goal is to improve the quality of care that is routinely provided to the patients of HMHD.

Quality Improvement Processes and Methodology:

The Quality Improvement Plan is a framework for the organized, ongoing and systematic measurement, assessment and performance improvement activities. The components of the plan include:

- A quick fix process will be used for problems that do not need a comprehensive approach to problem solving and solution implementation.
- Quality improvement teams, which may be inter or intradepartmental, and which look at particular issues to identify opportunities to improve processes and outcomes.
- Reports, which provide summary data about selected indicators, prepared for the board, Quality Improvement Committee and Medical Staff.
- Outside sources/comparable databases, professional practice standards, JCAHO, etc. will be used to compare our outcomes and processes with others, identifying areas to focus quality improvement efforts.

Quality Improvement Methodology:

PDSA:

- **PLAN** the improvement. Identify the opportunity for improvement; define your objective. Ask why are we doing this and how can we do it differently to make it better. Develop a multidisciplinary team; identify what you will measure.
- **DO** the improvement process. Collect and analyze data. Implement your change strategies. Do small changes.
- **CHECK/STUDY** the result. Understand the source of the errors. Review the re-measurement data. Were the results of the change better, worse or a lateral change?
- **ACT** to hold the gain and continue to improve the process. Follow up with documentation and report to the people involved.

SCOPE:

To achieve the goal of delivering high quality care, all employees are given the responsibility and authority to participate in the quality improvement program.

The Quality Improvement Program includes the following activities:

- All direct patient care services and indirect services affecting patient health and safety
- Medication therapy (includes medication errors)
- Nosocomial Infections
- Patient/Staff/Physician satisfaction surveys
- Professional staff credentialing
- Medical record review
- PEER review

QUALITY IMPROVEMENT COMMITTEE:

The Quality Improvement Committee consists of the following individuals: The CEO, Chief of Staff/Designee, Director of Nursing, Quality Improvement Coordinator, Infection Control Officer, representative from the Hospital Board of Directors, Dietary Supervisor, Housekeeping Supervisor, representative from Harm's Family Clinic, Pharmacy Technician, Medical Records director, Laboratory Director. The quality improvement committee will meet at least quarterly.

The members of the QI committee are responsible for:

- Assuring that the review functions outlined in the plan are complete;
- Prioritizing issues referred to the QI committee for review;
- Assuring that the data obtained through QI activities are analyzed, recommendations made, and appropriate follow up of problem resolution is done;
- Ensuring that QI projects selected are meaningful and measurable;
- Identifying other sources, such as the JCAHO's National Patient Safety Goals, for incorporation into the hospitals overall quality improvement efforts;
- Reporting on ongoing findings, studies, recommendations and trends to the Governing Board quarterly and annually; reporting to the Medical Staff monthly, and reporting to hospital staff as appropriate;
- Identifying educational needs and assuring that staff education for quality improvement takes place;
- Appointing sub committees or teams to work on specific issues, as necessary;
- Assuring that the necessary resources are available;

Communication:

The Quality Improvement Committee provides oversight and functions as the central clearinghouse for quality data and information collected throughout the facility. The QI Committee tracks, trends and aggregates data from all sources to prepare reports for the governing board and the medical staff.

Education:

All staff are given the responsibility and opportunity to participate in HMHD's Quality Improvement Plan. To fully accomplish this, all staff will be provided education regarding the QI plan during their initial orientation and on an annual basis thereafter. This education will include a description of the QI plan and how they fit into the plan, based on their particular job responsibilities. It will also include education regarding the QI methodology (PDSA).

Annual Evaluation:

Our QI plan will be evaluated on an annual basis for effectiveness in achieving the goal of assuring that the most appropriate quality of care was provided to our patients. A summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes to this QI plan, will be compiled and forwarded to the Governing Board for action.

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: Discontinued/Outdated drugs

EFFECTIVE DATE: 07-05-2010

DEPARTMENT: Pharmacy P-8

SUPERSEDES P&P DATED: NA

AUTHOR: Cassie Radtke

DATE: 07-05-2010

APPROVALS:

Pharmacist

Date

Board of Directors

Date

Administration

Medical Staff

Date

Date

Lee Tuck

7/14/10

[Signature]

14 JULY 2010

Dean L. Williams, MD

7-14-10

POLICY: Drugs which are outdated, have been recalled, or which have illegible or missing labels will not be used at Harms Memorial Hospital.

PROCEDURE:

1. All Personnel administering medication will check labels and expiration dates of all containers before administering any medications.
2. Drugs that are past its labeled expiration date will not be administered. All such drugs will be returned to the pharmacy to have a new supply issued.
3. Drugs with illegible labels will not be administered. All such drugs will be returned to the pharmacy to have a new supply issued.
4. The Pharmacy Technician will check all medication storage areas in acute care to include: ICU cabinet, Hospital cabinet, ER and ICU crash carts, and Hospital refrigerator at least monthly.
5. Pharmacist or pharmacy tech will check minimum stock levels.
6. Pharmacist or pharmacy tech will check for open vials or bottles to see if they are labeled with open date and expiration date.
7. Pharmacist or pharmacy tech will check expiration dates.
8. All meds that will expire within a month will be removed and replaced with stock with a later expiration date.

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: Safe Handling of Drugs

EFFECTIVE DATE: 07-05-2010

DEPARTMENT: Pharmacy

SUPERSEDES P&P DATED: NA

AUTHOR: Cassie Radtke

DATE: 07-05-2010

APPROVALS:


Department Manager

7/14/10
Date


Administration

14 JULY 2010
Date

Board of Directors

Date


Medical Staff

7-14-10
Date

POLICY: Safe dispensing and administration of drugs, developed by the Pharmacy and Therapeutics Committee and approved by the Medical Staff.

Procedures:

1. The Pharmacist shall review the prescriber's original order or a direct copy.
2. The RN Supervisor (after documented) training is designated by the pharmacist to do admixtures of parental products.
3. All medications shall be administered by trained personnel in accordance with accepted professional practices.
4. Regular continuing education will be provided thru coordinating efforts of Pharmacy and Nursing.
5. Each dose of medication administered shall be recorded according to policy as soon as administered in the patients MAR which is a separate and distinct part of the patient's medical record.
6. Drug reactions and medication errors shall be reported to the Physician and pharmacist.
7. A Pharmacist, on a yearly basis will do a training course for all Nursing. A Pharmacist Designee will train new nursing staff as they become employed with Harms Memorial Hospital.

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: Telephone, Written and Verbal Orders **EFFECTIVE DATE:** 07/15/2010

DEPARTMENT: Emergency/Outpatient **SUPERSEDES P&P DATED:** 2001

AUTHOR: ALICE TAYLOR R.N. **DATE:** 07/01/2010

APPROVALS:

Alice Taylor RN
Department Manager

7/14/10
Date

[Signature]
Administration

14 JULY 2010
Date

Board of Directors

Date

Dean L. Williams MD
Medical Staff

7-14-10
Date

POLICY:

- Verbal and telephone orders are allowed, however in an effort to reduce medication errors, the use of these types of orders is discouraged. The medical staff is educated on a continual basis to make all attempts to minimize the use of verbal and telephone orders. It is the policy of this institution never to allow verbal or telephone orders for the purposes of medical staff practitioner's convenience only. Whenever possible and practicable, all members of the medical staff with privileges and approval to prescribe medication, will do so by physically entering an order in the patient's medical record or on a Pharmacy prescription pad.
- Telephone and verbal orders for administration of medications may be received and recorded by pharmacists and other licensed personnel lawfully authorized to administer drugs. Such orders prescribed verbally or by telephone, are to be issued in the best interest of the patient and therefore will be kept to a minimum. Telephone and verbal orders for medication may be prescribed in the following instances:
 - The prescribing practitioner has determined that the patient is in need of medication within a specific time period and he/she is unable to physically write the order in the patient's medical record due to his/her physical

location. To delay administration of the medication would not be in the best interest of the patient's plan of care and treatment, therefore expedient ordering and administration of the medication is necessary.

- The prescribing practitioner has determined that the patient is in need of medication in an urgent or emergent situation, with verbal/telephone communication presenting the swiftest method of accomplishing the order.

PROCEDURE:

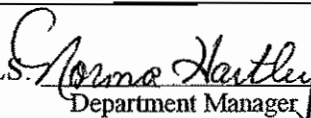
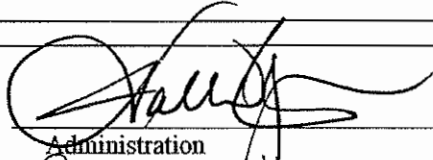
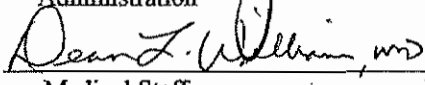
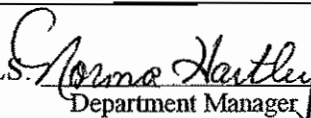
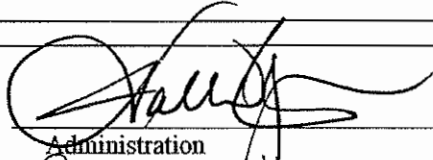
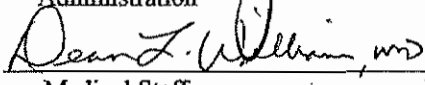
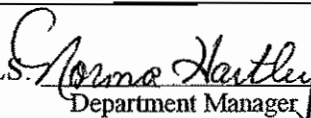
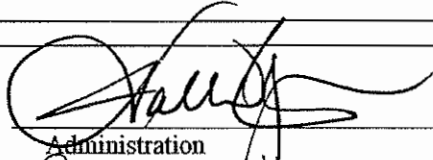
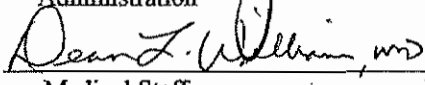
- Orders given verbally or by telephone for medications and their administration shall be filled only when given by a qualified physician, surgeon, dentist, podiatrist or other person duly licensed or authorized to prescribe by the State of Idaho, and who has been approved as a member of the medical staff of this hospital. All verbal/telephone orders of medication shall be transcribed in writing into the medical chart of the patient or, if appropriate, on a prescription form if taken by a Pharmacist.
- All verbal and/or telephone orders for medications shall include the following criteria:
 - Date and time the order is prescribed verbally or via telephone
 - The name of the individual prescribing the drug and his/her licensure (i.e., MD, DPM)
 - The name of the drug
 - Drug dosage (strength or concentration)
 - Quantity and/or duration
 - Route drug is to be administered
 - Frequency of administration
 - Age and weight of the patient if this is appropriate
 - Known allergies (if this has not been determined at the time of the verbal/telephone order)
 - Name and level of licensure of the individual receiving and documenting the order
- Verbal/telephone orders of medication shall be received and recorded by the Pharmacist or licensed nurse, approved by the medical staff of this hospital to

receive and record verbal/telephone orders. This shall preclude the taking of a verbal order by a specialty technician within the scope of their specialty allowed by law and approved by the medical staff, which include the Respiratory Therapist, Physical Therapist, Radiology/Imaging Technician and Nuclear Medicine Technician.

- To prevent medication errors related to verbal/telephone orders, all individuals licensed and approved by this hospital to receive and record these types of orders must strictly observe the following practices when performing this function. The receiver of the order must:
 - Obtain all criteria information for medication verbal/telephone orders listed above.
 - Repeat the entire order to the prescriber, spelling the name of the drug or requesting the prescriber to spell the drug if the receiver does not know the spelling.
 - Document that the read back of the order is complete by checking the ☐ RBO box and signing.
 - All verbal/telephone orders shall be transcribed (recorded) in the metric system, excluding medications/therapies that use standard units such as insulin.
 - Record the verbal/telephone order immediately in the patient's medical record or, for pharmacists, on a prescription form as appropriate.
 - Indicate either telephone or verbal order in the written record.
 - Sign the written record and indicate level of licensure.
- The prescribing practitioner must sign the written record of the verbal/telephone order within 48 hours of giving the order.

HARMS MEMORIAL HOSPITAL DISTRICT
American Falls, Idaho

POLICY AND PROCEDURE

TITLE: Utilization of Staffing Agency Personnel	EFFECTIVE DATE: 06/2010				
DEPARTMENT: Human Resources	SUPERSEDES P&P DATED:				
AUTHOR: Norma Hartley	DATE: 06/01/2010				
<table style="width: 100%; border: none;"><tr><td style="width: 50%; vertical-align: top;">APPROVALS:  _____ Department Manager _____ Board of Directors</td><td style="width: 50%; vertical-align: top;"> _____ Administration  _____ Medical Staff</td></tr><tr><td style="text-align: center; vertical-align: bottom;">7-14-10 Date</td><td style="text-align: center; vertical-align: bottom;">14 JULY 2010 Date 7-14-10 Date</td></tr></table>		APPROVALS:  _____ Department Manager _____ Board of Directors	 _____ Administration  _____ Medical Staff	7-14-10 Date	14 JULY 2010 Date 7-14-10 Date
APPROVALS:  _____ Department Manager _____ Board of Directors	 _____ Administration  _____ Medical Staff				
7-14-10 Date	14 JULY 2010 Date 7-14-10 Date				

POLICY:

Ensure all staffing agency personnel utilized by Harms Memorial Hospital District (HMHD) are properly trained, licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.

PROCEDURE:

When HMHD utilizes agency personnel the first time, the HMHD nurse calling the agency will request copies of certification, licensure, proof of immunizations, background and reference checks, or a check list provided by the agency verifying this information has been completed, is on file, and current.

If the agency staff member is a certified nurse aide, the agency must provide proof the C N A had sixteen (16) hours of in-service prior to working at HMHD.

Binders containing orientation packets for agency personnel (certified nurse aide, licensed practical nurse, and registered nurse) are located at the Acute Care Nurse's Station and the downstairs Long Term Care Nurse's Station. All paperwork in the orientation packet will be completed the first time any agency staff member covers a shift at HMHD.

The paperwork includes the following:

- Orientation checklist (HMHD employee and agency aide/nurse signs & dates)
- Job description (agency aide/nurse signs & dates)
- Abuse statement (agency aide/nurse/signs & dates)

Utilization of Agency Staffing Policy and Procedure
Page 2

The paperwork includes the following continued:

- Notice of Privacy Practices (agency aide/nurse signs & dates)
- Pledge of Confidentiality (HMHD employee and agency aide/nurse signs & dates)
- Resident Rights (agency aide/nurse signs & dates)
- Complaint & Grievance Policy (agency aide/nurse signs & dates)
- Abuse & Neglect Policy (agency aide/nurse signs & dates)

The HMHD employee providing the orientation will review the packet at the time of the orientation to ensure the paperwork has been completed and all signatures are in place.

**Harms Memorial Hospital District
Amendment to Medical Staff By-Laws**

EMTALA Requirements

Page 10

Article 2 Membership

2.7 EMTALA Requirements

The intent of this change to the by-laws is to allow for the RN on duty in the Emergency Department, if specifically approved by the Medical Staff, to perform the medical screening.

The By-laws currently read as follows:

“Patients for emergency treatment will receive a nursing assessment as per hospital policy. The emergency department provider will be notified. A medical screen will be performed on all patients presenting for emergency treatment. The provider on duty in the emergency department will perform this screen.....”

The By-laws are hereby amended to read as follows:

All patients presenting to the Emergency Department will receive a *Medical Screening Examination (MSE)*. The MSE will be performed by Qualified Medical Personnel (QMP), which may be any active member of the Medical Staff (DO, MD) or mid-level practitioners (PA, FNP). Registered Nurses (RN) may be individually approved to perform the MSE in consultation with the on-call provider. The purpose of the MSE is to determine, within the capability of this facility, the existence of an emergency medical condition. If an emergency medical condition is deemed to exist, the hospital will provide stabilizing treatment or properly transfer the patient to another facility in accordance with Federal EMTALA regulations.

Dean L. Williams, MD
Chief, Medical Staff

[Signature]
Administrator

Chairman, Board of Directors

7-14-10

Date

14 JULY 2010

Date

Date

**HARMS MEMORIAL HOSPITAL DISTRICT
RULES AND REGULATIONS OF THE MEDICAL STAFF**

Revised 07/10

These rules and regulations are adopted in accordance with Harms Memorial Hospital District's Medical Staff by-laws.

PERTAINING TO THE MEETINGS:

The meetings of the medical staff shall be held as provided for in the medical staff by-laws.

PERTAINING TO ADMISSIONS:

1. Except in an emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.
2. There will be a history, physical and diagnosis completed within twenty four (24) hours after admission.
3. Physicians admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever.
4. Patients shall be attended by their own private physicians. Patients being admitted who have no private physician shall be assigned to the physician member of the active medical staff on call duty.
5. Laboratory and radiology services shall be provided in the hospital to insure as complete a service as possible. Examinations which cannot be made in the hospital shall be referred to an approved outside laboratory or radiology service.

PERTAINING TO ORDERS

1. Standing orders shall be formulated and approved by the medical staff and the administrator. They may be changed by the administrator of the hospital only after conference with and approval of the medical staff. These orders shall be followed insofar as proper treatment of the patient will allow, and when other specific orders are not written by the attending physician or dentist, they shall constitute the orders for treatment. They shall be signed by the attending physician.
2. All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a registered nurse or a licensed practical nurse and signed by the nurse with her/his name and the doctor's name. The attending physician shall co-sign this order within forty-eight (48) hours. Orders dictated over the telephone shall be signed by the nurse who took the order, with the name of the physician and his/her own name. At the next visit the attending physician or dentist shall co-sign such order but not longer than forty-eight (48) hours. Patients shall be discharged only upon written or telephone order of the attending physician or dentist. Patients shall be discharged prior to 2:00 p.m.

PERTAINING TO ORDERS continued:

except under exceptional circumstances. At time of discharge, the attending physician or dentist shall complete the records, state his/her final diagnosis, and sign the records.

3. Providers will prescribe hospital formulary drugs when possible and medically indicated.
4. For all emergency department patients, providers will dictate or write a record of exam at the time of the ED patient visit. If an emergency occurs and the dictation/notes cannot be completed at the time of service, the provider must complete the dictation/notes at the earliest opportunity and include documentation as to why the dictation/notes are late.

PERTAINING TO MEDICAL RECORDS

1. Preparation of the following components of medical record for each patient shall be the responsibility of the attending physician.
 - a. The medical record shall contain sufficient information to justify the diagnosis and warrant the treatment and end results.
 - b. The record shall be sufficiently complete that if it becomes necessary for another physician to continue the case, he/she could do so without detriment to the patient.
 - c. The record shall ordinarily include when applicable: Identification data, complaint(s), personal history, family history, history of present illness, physical examination, provisional diagnosis at time of admission, special reports, eg. Consultations, clinical laboratory, radiology etc., medical or surgical treatment, pathological findings, progress notes, final diagnosis, condition on discharge, follow-up, discharge summary and autopsy report.
 - d. Seriously ill and difficult cases usually shall require more extensive elaboration of the record than routine, uncomplicated cases.
 - e. In specific instances, decision as to whether or not a patient's record is sufficiently complete may be made at the regular medical staff meeting after careful review of the medical record medical director.
 - f. No medical record shall be filed until it is completed.
2. Adequate history and physical examination shall in all cases be written or dictated within twenty four (24) hours after admission of the patient.
3. An interim admission note that includes only the chief complaint, history of present illness and physical exam with pertinent labs, pathology, and x-ray results may be used only for patients who are readmitted with the same diagnosis within thirty (30) days.
4. All operations and procedures performed shall be fully described in writing or dictation by the operating surgeon and procedurist within twenty four (24) hours of surgery/procedure. All tissues removed at operation shall be sent to the hospital pathologist, who shall make such examinations as he may consider necessary to arrive at a pathological diagnosis and shall sign his report.
5. All residents shall be seen in the nursing home section of the facility at least every thirty (30) days the first three months and every sixty (60) days thereafter. Progress notes shall be written or dictated within forty eight (48) hours of each visit.

PERTAINING TO MEDICAL RECORDS continued:

6. After discharge, records should be complete insofar as possible within fifteen working days; these days shall not include provider time off for vacation, medical education, or illness. The records department shall review the incomplete charts at least monthly, and advise in writing, each physician who has any incomplete charts, or who has any charts within ten (10) days, that he/she must complete these charts within ten (10) days, or not admit patients to the hospital or nursing home until his/her charts are completed.
7. All records are the property of the hospital district and shall not be taken away from the facility. In case of readmission of a patient, the attending physician shall make all previous medical records available for use.
8. The records pertaining to any patient shall be available for use (consistent with preserving confidentiality) of any physician who is attending the patient, whether the patient is or is not in the hospital. Under like conditions, the record shall be available to staff physicians in good standing, for bona fide research.
9. A discharge summary shall be completed at the earliest reasonable time possible by the discharging physician when a patient is discharged, and shall contain brief notations concerning: entering complaint, history, physical findings, pertinent lab and radiology findings, treatments (including complications), hospital course, condition on discharge, follow-up instructions and treatment.
10. The fact that a patient is admitted to the hospital (or that any outpatient treatment or procedure is ordered), shall attest to the judgment of the attending physician; and continued presence of the patient in the hospital under doctor's orders shall be defector indication of the need of continuing hospitalization.

PERTAINING TO CONSULTATION:

1. A satisfactory consultation shall include examination of the patient and the record, and a written opinion signed by the consultant and filed in the medical record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded or dictated prior to operation.
2. A consultant shall be well qualified to give an opinion in the field in which his/her opinion is sought. He/she must have major privileges in the respective field or procedure.
3. The responsibility for requesting consultation rest with the patient's physician. It shall be the duty of the medical staff to make certain that staff members do not fail to request needed consultations.
4. Consultations are usually required is cases in which, according to the judgment of the attending physician:
 - a. The patient is not a good medical risk.
 - b. The diagnosis is obscure.
 - c. There is doubt as to the best therapeutic measure to be utilized.
 - d. There is question of criminal action.

PERTAINING TO CONSULTATION continued:

5. The consultant shall make and sign a record of his/her findings and recommendations in every case.

PERTAINING TO MEDICAL STAFF:

1. The medical staff discussions at meetings held as provided for in these rules and regulations shall consist of a thorough review and analysis of the clinical work done in the hospital, including quality control. Things that may be looked at will include but not be limited to: consideration of deaths, unimproved cases, infections, complications, errors in diagnosis and reports from committees of the medical staff.
2. Only physicians who have submitted proper credentials and have been duly appointed to membership on the medical staff may treat patients in the hospital or nursing home.
3. The hospital shall admit patients suffering from all types of disease as qualified by staff privileges and Harms Memorial Hospital District's credentialing process, except active tuberculosis when such condition has existed prior to the patient being admitted to HMHD.
4. All medical providers, including Locum Tenens will give copies of their current Idaho Medical license and malpractice insurance (or note of coverage from their insurance company) annually or whenever a change is made to the Credentials Coordinator.
5. The chief of staff shall appoint a member of the medical staff for annual appointments as outlined in the Medical Staff By-laws of the district.
6. Whenever there is a change in officers of the medical staff the by-laws and rules and regulations will be reviewed and signed by the new officers and members of the medical staff.

ADOPTED BY THE MEDICAL STAFF

Date

7-14-10

Dean L. Williams, MD

Chief of Medical Staff

ADOPTED BY THE BOARD

Date

Chairman of the Board

HARMS MEMORIAL HOSPITAL DISTRICT

Quality Care Close to Home

July 23, 2010

Sylvia Creswell
Idaho Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

RECEIVED

JUL 23 2010

FACILITY STANDARDS

Doc e-mail 1:49 pm

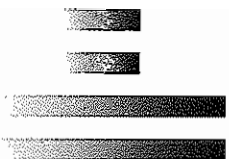
Re: Harms Memorial Hospital, CCN# 131304

Dear Ms. Creswell:

Attached is an addendum to our plan of correction that was filed with your office on July 15, 2010 and includes points which were intended to be part of the original plan of correction. Since the date of completion is July 23, 2010, we respectfully request that this addendum be included in and made a part of the original plan of correction emailed to your office on July 15, 2010.

Harms Memorial Hospital District is attempting to correct all of the deficiencies that were cited and we have engaged Kim Stanger, attorney with Hawley, Troxell, Ennis and Hawley to help us. Additionally, we have consulted with Nanette Hiller, Director of Performance Improvement with the Idaho Hospital Association, Steven Millard, Executive Director with the Idaho Hospital Association and John O'Hagan, Risk Management Consultant with Chivaroli and Associates. This addendum includes suggestions from each of these parties.

Our Board of Trustees, our Medical Staff and I as the Chief Executive Officer take very seriously the issues raised in these surveys. We are very appreciative of the opportunity to make corrections and improve the level of care for all patients utilizing Harms Memorial Hospital District. We look forward to your review of the documentation that we have submitted including this addendum. We look forward to the surveyors returning to our facility before August 3 to review the changes we have made and the new policies we have implemented. We look forward to working with the surveyors to ensure the highest quality of care here at Harms Memorial Hospital District.



HARMS MEMORIAL HOSPITAL DISTRICT

Quality Care Close to Home

July 23, 2010

Sylvia Creswell
Idaho Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

RECEIVED

JUL 26 2010

FACILITY STANDARDS

Re: Harms Memorial Hospital, CCN# 131304

Dear Ms. Creswell:

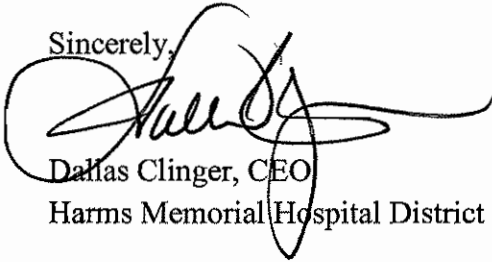
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If there are any questions or concerns you have as you review this addendum, please contact me on my cell phone at 208-317-6970 and I will be at your service to answer whatever questions or concerns that you may have.

Sincerely,

A handwritten signature in black ink, appearing to read "Dallas Clinger", with a large, stylized flourish extending to the right.

Dallas Clinger, CEO
Harms Memorial Hospital District

Harms Memorial Hospital District

Addendum to Plan of Correction Submitted July 15, 2010

July 23, 2010

Page 5, Paragraph 1

A special meeting of the Board of Trustees was called and held on July 22, 2010. This meeting was called specifically to act upon the new policies and Medical Staff Bylaws in order to have them officially accepted before our completion date of July 23, 2010. All new policies and the Medical Staff bylaws were accepted by the Board of Trustees and signed by the Chairperson of the board.

Page 5, Paragraph 2

Examples of the meaningful and measurable goals and data driven measures we are now employing include: listing all incidents in the facility, monitoring numbers of medication errors, falls, skin issues, and any other incidents. Tracking who commits errors, type of error and analyzing the errors monthly to determine if staff is being deficient or if changes in the system are needed; monitoring medication storage areas for outdated drugs and that checks are being done as directed; tracking all medication taken from the pharmacy and the disposition of the medications; tracking numbers of re-takes in radiology; monitoring turnaround time for maintenance work orders; tracking to ensure that physical therapy notes are in the charts within 48 hours; tracking to ensure that providers document their examination notes for patients in the emergency room during their shift; tracking to ensure that occupational and speech therapy are notified of orders for their services within 24 hours; monitoring blood cultures and analyzer maintenance and pre and post analytical testing requirements to ensure they are done, among other things. The QI committee will discuss all data gathered, it will be presented to medical staff and the governing board and they will all look at the data gathered and determine if acceptable levels of compliance are being achieved and if not why.

Page 8, Paragraph 1

This corrective action should contain the statement that "The DON will audit all charts for a period of 3 months, and if compliance is not at least 95% the DON will monitor for an additional 3 months."

Page 9

This paragraph should contain the statement that “The Medical Records Director will generate a QMM for all providers who fail to sign verbal orders within 48 hours for 6 months, and if 98% compliance has not been achieved this will continue for another 6 months.

Page 9, at the bottom of the paragraph

At the bottom of the paragraph, we stated that “This corrective measure will be instituted by 07/23/2010 and will...” Since this corrective action in question is one which discusses a long standing regulatory requirement we implemented the corrective action on 6/25/2010 and we wanted the plan of correction to reflect the fact that this action is already in place and has been since 6/25/2010.

Page 10, Paragraph 2

This paragraph should contain the statement that “Undocumented emergency department examinations will be added to our QI indicators and specifically tracked and reported monthly for at least the next 6 months, at which time if compliance is not at 100%, we will continue to monitor for 6 more months”.

Page 11, #3

This point should include the statement “Attached please find the outline of topics covered in the nursing staff meeting given by Alice Taylor DON on 07/15/2010 (see attached)”.

Page 12, Paragraph 1

This paragraph should contain the statement that “100 % of charts will be monitored for a period of 6 months, and if 95% compliance has not been achieved at the end of 6 months we will continue to monitor for an additional 6 months”.

Pages 13 through 18

A new paragraph should state: “The deficiencies that the surveyors brought to our attention in items 2(a) through 2(d) have been taken back to the providers for documentation. The deficiencies relating to Medication Administration and identified in items 3(a) through 3(b) on pages 15 through 17 were included in the in-service given to the nursing staff by Alice Taylor, DON on July 15, 2010.

Page 20, item 2

This item should include the statement that “Chart audits, 24 hour chart checks and pharmacy and nursing MAR reconciliation will continue for 6 months, and if 95 % compliance is not achieved it will continue for an additional 6 months”.

Page 33, Item 3

This should include that statement that “Chart audits, 24 hour chart checks and pharmacy and nursing MAR reconciliation will continue for 6 months, and if 95% compliance is not achieved it will continue for an additional 6 months”.

HOSPITAL NURSING STAFF MEETING
07/15/2010

1. DOCUMENTING TELEPHONE, VERBAL AND WRITTEN ORDERS: This policy has been updated (attached). All verbal and telephone orders need date and time, drug name, dose, frequency, quantity or duration, route, name and level of licensure of prescriber, name and level of licensure of person taking order. If a verbal or telephone order is not written in the correct format this is a medication error and a QMM will be done on it. Staff who have repeated med errors will be counseled, educated and have possible disciplinary action.
2. ORDERS FOR NARCOTICS WHEN K. BABB IS PROVIDER: When a narcotic is needed the provider will call the back up physician, never a NP, and will explain what is needed, the phone will then go to the RN who will take the telephone order and write it on the chart and carry it out. This will be the policy and proper procedure until further notice so don't quit doing it this way until you are educated to do this procedure differently.
3. MONITORING PTS WHO GET MEDS: You MUST monitor a patient who receives medication in the ER or OP depts. For 15 minutes to observe for side effects of reactions. You MUST always do repeat vital signs on patients.
4. READ BACK PROCESS: When taking a telephone or verbal order you must read the order back to the provider to ensure that you have transcribed the order properly. Also you need to check that you did the RBO and sign at the bottom of the order form.
5. 24 HOUR CHART CHECK: The 24 hour chart check is part of the system we use to find medication errors. All night nursing staff will do a 24 hour chart check using the form to guide you and fill out a QMM for any errors found. Also note *on the chart* that this was done.
6. CHECKING FOR OUTDATED MEDICATIONS: The system for checking for outdated medications is the same. There is an assignment sheet posted at the nurses station. The checks need to be filled out completely and signed and DATED!! Use care when doing this as the cabinets had been checked and then surveyors found outdated drugs.

7. IV COMPOUNDING OF MEDICATIONS: Please refer to the policy (attached), and make sure you follow all the proper procedures we have been taught regarding mixing IV medications. If there is ever a question regarding mixing or infusing medications you can call our pharmacist, or the pharmacist at Porneuf. These telephone numbers are posted at the nurses station.
8. NEW PROVIDER ORDER AND EXAM FORM
9. NEW TRANSFER FORM
10. DISCUSSION

SIGNATURE

DATE

SIGNATURE

DATE